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A Constructivist Examination of Counselors' Conceptualization of "Sexuality": Implications for Counselor Education

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A CONSTRUCTIVIST EXAMINATION OF COUNSELORS'
CONCEPTUALIZATION OF "SEXUALITY": IMPLICATIONS FOR COUNSELOR
EDUCATION

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DEDICATION

For

My Grandmothers, Velma and Mary

Through their life and their death, these women emulated grace and humility, strength and determination. Their character commanded my respect without ever demanding it.

My Children

Connected by blood, love, or dedication, both those who have been brought into my life and those yet to be born, have both humbled and inspired me.

My Husband

When you entered my life, you brought an abundance of unexpected blessings for which I am so thankful. No matter where we are, I am home.

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ABSTRACT

Due to the dialectical dilemma between meeting the demands of the managed health care industry through the adherence to the medical model while promoting an emphasis on wellness, the counseling profession does not promote a consistent definition of sexuality. Using a qualitative, phenomenological approach from a constructivist lens, this study was conducted to examine the construct “sexuality” and “sexuality counseling” from counselors’ perspectives. One synchronous online focus group and two online individual interviews were conducted with counselors predominantly in the Southeastern United States. Themes from the data include: Sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training in counseling is insufficient. Implications of these findings for counselors, counselor education, training, and supervision are discussed.

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CHAPTER I

INTRODUCTION

Floating on a river, I am pushed by currents on either side. If the current is too strong on one side, I become stuck on the bank. If the opposing currents become entangled in a swirl, I become stuck in an eddy. However, if the two opposing forces meet with equal or alternating strength, then I am pushed down the river through the shimmering water in the sunshine and through the shadows beneath the trees, alternating between warmth and chill, clarity and darkness, but definitely moving forward. The force and temperature of the water, my confidence as a swimmer, and my ability to navigate, as well as the water and air creatures I encounter, all influence my experience (Toporek, 2011, p. 405).

Like the currents in the river, the personal experiences, socialization, and training of each counselor influence his/her perceptions and determine how each aspect of human experience is conceptualized and defined. These conceptualizations are expressed through language. Language, in turn, serves to maintain the meaning of experiences and shapes the perceptions of others, which is then accepted as reality (Prawat, 1996; Prawat & Floden, 1996; Warmoth, 2000). In Counseling, contrasting conceptualizations of the definition of health have led to a dialectical dilemma in the profession, particularly as it

relates to sexuality (Beasley, 2008; Bullough, 1975; Diamond & Huebner, 2012; Larson, 1999; Myers, 1991; Swarbrick, 2006; Tiefer, 2010; Zalaquett, et al, 2008). While the tension in the Wellness and Medical Model approaches to health has persisted for an extensive period of time, the recent “sexuomedicalization” (Tiefer, 2010, p. 198) or the phenomenon of sexuality being medicalized has resulted in a “sexual socialization” (Paiva, 2005, p. 346), the normalization of sexual dysfunction.

The logical result of the sexual dysfunction lens is the determination that an individual requires a specialist to address sexual concerns and the oversimplification of sexuality in terms of mechanical function (Beasley, 2008; Bradley & Fine, 2009; Bullough, 1975; Murray, 2006), while omitting other aspects and factors that influence sexuality (Hogben & Byrne, 1998; Sachs & Duffy, 1976; Simon & Gagnon, 1984, 1986; Tiefer, 2006, 2010; Trimble, 2009; van der Kwaak, Ferris, van Kats, & Dieleman, 2010). In contrast, wellness approaches have emphasized a developmental perspective of human behavior but have not included a clear definition of the role of sexuality in overall wellness (Myers, 1991; Myers & Sweeney, 2005, 2008; Myers, Sweeney, & Whitmer, 2000; Nosek, et al, 1994; Roscoe, 2009). At either extreme, the understanding and role of sexuality in Counseling has been limited. As sexuality is one aspect of human experience caught in the conflict between wellness and dysfunction, further examination of the experience of sexuality in counseling may provide perspective into how the meaning of sexuality is conceptualized for counselors.

According to the social psychological constructivist viewpoint, experiences and behaviors are expressed and maintained through the language created to communicate them, leading to the focus for exploring meaning being the *words* chosen by a community

for the construct of interest (Prawat, 1996). The language used to express a construct has a powerful influence over the members of a community because it shapes the overall worldview (Prawat, 1996; Toporek, 2011). Therefore, efforts to impact the philosophy of sexuality training and interventions must begin with a discussion of the language used to express these concepts (Diamond & Hubener, 2012; Elders, 2010; Paiva, 2005; Trimble, 2009). From this perspective, framing sexuality in terms of dysfunction, through providing instruction based predominantly on the Diagnostic and Statistical Manual of Mental Disorders (DSM), would inevitably have an impact on the meaning that counselors place upon sexuality (American Psychiatric Association (APA), 2000; Beasley, 2008; Council for the Accreditation of Counseling and Educational Related Programs (CACREP), 2009).

Although counselor education programs may not directly emphasize the sexual dysfunction schema, the medical model perspective may be reinforced with respect to sexuality, due to the emphasis in counselor education on DSM-focused diagnostic training while omitting required training in sexual wellness for many counselors in training (CACREP, 2009). With an emphasis on the DSM in training programs, counselors may rely on a sexual dysfunction model and either avoid the topic or refer to a sex therapist, leading to perpetuation of stigma surrounding sexuality and lack of opportunity to increase competency in sexuality counseling.

In Counseling, sexuality has been treated as a specialty area for which extensive training is required (Gill & Hough, 2007; Nasserzadeh, 2009; Southern & Cade, 2011). Lack of training may be one reason many counselors reported feeling uncomfortable addressing sexual issues with their clients (Parritt & O'Callaghan, 2000; Southern &

Cade, 2011). To complicate matters, the nature of sexuality interventions has been consistently unclear with regards to who provides the interventions and what treatments require specialized training (Elders, 2010; Gill & Hough, 2007).

Wellness approaches have been suggested as a framework for addressing sexuality in counseling with specific populations, such as women with disabilities and female childhood sexual abuse survivors (Hodges & Myers, 2010; Myers, 1991; Nosek, et al, 1994). Wellness approaches affirm that the definition of health goes beyond not having a disease or disorder to include “a state of complete physical, mental, and social well-being” (Nosek, et al, 1994; Roscoe, 2009, p. 216). However, wellness models also limit the definition of sexuality to a couple experience and emphasize gender identity and intimacy over sexual expression (Myers & Sweeney, 2005, 2008; Roscoe, 2009).

The narrowly-focused arguments regarding sexuality, focus on sexual dysfunction, and the lack of clear definition about what sexual behavior constitutes health and what constitutes dysfunction leaves counselors professionally unarmed in addressing sexuality, leading to lack of intentionality and awareness. Lack of intentionality and awareness increase the risk of harm through infusing personal biases, values, and judgments into interventions, perpetuating both the sexual myths and the incompetence of counselors to address sexuality with clients. To truly adopt theoretical perspectives regarding sexuality, whether medical or wellness focused, the ambiguity of the construct of sexuality in counseling has to be clarified.

Problem Statement

When the information provided in Counselor Education programs focuses on dysfunction and social taboos, the potential for several consequences arises. Counselors

may internalize a view of sexuality rooted in dysfunction, leading to the invalidation of clients' experiences through the use of language rooted in a binary conceptualization (Beasley, 2008; Tiefer, 2010; Trimble, 2009). Counselors may also be more likely to avoid training and clinical opportunities in sexuality due to personal discomfort, leading to a self-fulfilling prophecy of incompetence (Bogey, 2008; Fyfe, 1980; Giami & Pacey, 2006; Gill & Hough, 2007; Jackson, 2010; Southern & Cade, 2011). Finally, counselors and clients may overlook sexuality in the counseling process due to socially imposed stigma that they may both accept as reality.

Sexuality interventions in counseling are perceived as a specialization, leading to many counselors providing a referral rather than an intervention (Giami & Pacey, 2006; Nosek, et al, 1994; Paiva, 2005; Tiefer, 2006). In spite of periods of focus on sexual health and wellness in the literature, there has not been a significant shift to reject the sexual dysfunction lens in practice (Fyfe, 1980; Giami & Pacey, 2006; Nosek et al, 1994; Tiefer, 2006; Trimble, 2009). To date, research has either been philosophical or quantitative in nature, and no research has been conducted on counselors' perceptions of sexuality in their clinical practice. From the social psychological constructivist perspective, understanding the language counselors use to express their perceptions of sexuality will provide insight into the way that the counseling profession conceptualizes sexuality, leading to an opportunity to clarify professional values regarding sexuality counseling.

While the literature has emphasized the need for further research in sexuality counseling (Hays, 2000; Parritt & O'Callaghan, 2000), no research to date has been conducted on the meaning and language that counselors attribute to sexuality. Defining

sexuality and sexuality counseling from this lens is essential to begin to establish consensus within the profession regarding the degree and manner in which counselors are trained to provide sexuality counseling. In addition, an exploration of the meaning of sexuality will assist in the development of a sexual wellness model to structure sexuality interventions with clients and provide an alternative to the medical model approach currently dominating sex therapy (Nasserzadeh, et al, 2009; Southern & Cade, 2011).

Need for the Study

As consistency in the conceptualization and definition of sexuality is lacking in the counseling profession, the construct of sexuality from counselors' perspectives will be explored. The dialectical dilemma in sexuality counseling appears to be rooted in the conflict between medical model and wellness-based approaches in the profession (Beasley, 2008; Diamond & Hubener, 2012; Elders, 2010; Myers & Sweeney, 2005, 2008; Nosek, et al, 1994; Swarbrick, 2006; Tiefer, 2010). This conflict is evident in and perpetuated by the language that is utilized to conceptualize sexuality (Beasley, 2008; Lazarus, 2008; Paiva, 2005; Prawat, 1996; Tiefer, 2010). The meaning associated with sexuality varies depending on the lens from which it is viewed.

From a developmental perspective, sexuality is determined to vary throughout the lifespan based upon age and stage of life (Southern & Cade, 2011). The most prominent developmental perspective of sexuality can be attributed to Sigmund Freud, the author of the theory of psychosexual development. Freud perceived the life stages as defined by an individual's sexual development. Specifically, Freud perceived sexual urges as the foundation for sexual interest and behavior, with particular attention to abnormal sexual behavior (Lazarus, 2008). His work had a significant influence on the psychology

profession and established language specific to sexuality. For example, Freud defined healthy sexual functioning for women as the ability to move from clitoral to vaginal orgasm (Irvine, 1990).

From a sociological perspective, sexuality is viewed as a social behavior with norms determined by social and cultural factors (Diamond & Hubener, 2012; Lazarus, 2008; Paiva, 2005; Southern & Cade, 2012; Trimble, 2009). The social learning theory asserts that sexual pleasure is a powerful reinforcer for sexual behavior, learned through modeling (Hogben & Byrne, 1998; Petersen & Hyde, 2010; Sachs & Duffy, 1976). Because sexuality is viewed as a subjective experience, the sociological research emphasizes the fluidity of sexuality without clarifying the construct.

The medical model focuses on the biological aspects of sexual functioning and behavior based upon the sexual response cycle (APA, 1952; APA, 1968; APA, 1980; APA, 1994; APA, 2000; Bradley & Fine, 2009; Sexuality Encyclopedia, 2012). In addition, sexuality is defined as an experience shared within a couple context (Lazarus, 2008). In the medical model, the emphasis is placed upon the rapid alleviation of symptoms contrary to the sexual response cycle (Bullough, 1975; Southern & Cade, 2011). While the definition of sexuality is consistently focused on objective physiological aspects, the social and cultural influences are omitted in the definition of sexual functioning (Tiefer, 2006; Trimble, 2009).

Wellness approaches show some consistency in perceiving sexuality as a holistic and developmental experience, embracing sexual expression as a key aspect of personality and emphasizing variation from the binary system of conceptualizing gender identity and roles (Roscoe, 2009; Southern & Cade, 2011; Trimble, 2009). While

sexuality is viewed as essential to overall wellness (Beasley, 2008; Paiva, 2005), it is not highlighted as a core dimension in wellness models (Myers & Sweeney, 2005, 2008; Roscoe, 2009). According to the Indivisible Self Model, healthy sexuality is viewed in terms of love/relationships and gender/sex roles, neglecting the sexuality of other stages across the lifespan (Myers & Sweeney, 2005, 2008). In spite of the emphasis on expanding the definition of sexuality beyond the binary perspective, wellness models lose the consistency found in the medical model in favor of extremely general conceptualizations.

Inconsistencies in defining sexuality contribute to lack of clarity regarding the nature and scope of sexuality counseling. Although sexuality is perceived as developmental, sexuality counseling is perceived as a specialization without clear parameters (Southern & Cade, 2011). The term sexuality counseling is used across disciplines, and it is viewed as the promotion of sexual health (van der Kwaak, van Kats, & Dieleman, 2010). In contrast, emphasis in sexuality training is focused on sex therapy programs, which focus on medicalized interventions for sexual dysfunction (Southern & Cade, 2011). In counseling, the Council for the Accreditation of Counseling and Related Educational Programs (CACREP) does not require sexuality counseling training for any concentration except marriage and family counseling, which further reinforces both the perception that sexuality only pertains to couples and that sexuality interventions are a specialty (CACREP, 2009).

Professional standards for sexuality counseling are outlined by the American Association of Sex Educators, Counselors, and Therapists (AASECT). Although the organization provides a clear definition for sexuality counseling and outlines specific

training and practice criteria, these criteria are not intended for masters-prepared clinicians. Instead, professionals with a graduate degree are required to seek certification as a sex therapist instead (AASECT, 2012; Southern & Cade, 2011). From this lens, sexuality counselors are not qualified to treat sexual dysfunction, and the sex therapy field is focused on medical interventions, leaving counselors in a position of professional confusion regarding qualification to provide intervention and education regarding sexual concerns with clients.

Much education and training on sexuality focuses on deviance, risk, and physiological functions in sexual behavior (Bradley & Fine, 2009; Giami & Pacey, 2006; Weerakoon, Sitharthan, & Skowronski, 2008; Zwibelman & Hinrichsen, 1977), whereas research emphasizes focusing on sexual pleasure and health (Beasley, 2008; Diamond & Hubener, 2012; Elders, 2010; Nosek, et al, 1994). Use of the term “sexual health” is confusing due to the content often being based on risk and dysfunction (Southern & Cade, 2011). As language is the vehicle to communicate the meaning associated with sexuality (Murphy, 1997; Prawat, 1996; Prawat & Floden, 1994; Warmoth, 2000), counselors may become stuck in the conceptualization of sexuality between language that implies risk and dysfunction and trying to provide interventions based on developmental and wellness perspectives.

Counselors appear to be confused regarding the nature and scope of sexuality interventions. While some believe that sexuality counseling is a specialization (Nasserzadeh, 2009; Southern & Cade, 2011), others are of the opinion that it is an essential skill for all counselors (Bogey, 2008; Fyfe, 1980; Jackson, 2010; Parritt & O’Callaghan, 2000; Tiefer, 2006; Trimble, 2009; van der Kawaak, Ferris, van Kets, &

Dieleman, 2010). Inconsistency in the perception of providing interventions related to sexuality could contribute to feelings of incompetency and avoidance of addressing sexuality with clients (Parritt & O’Callaghan, 2000). To clarify the nature of sexuality counseling, it is first necessary to explore the meaning that counselors attribute to sexuality. Exploring the language and meaning associated with sexuality will allow a discourse to take place within the counseling profession about perceptual inconsistencies. An increase in dialogue could lead to the determination of terminology that is consistent with the developmental roots of the profession and conceptualize sexuality from a holistic perspective. Establishing a common language alternative to the medical model could enhance sexuality training and interventions by empowering counselors to assess and address sexuality with clients with the intention of incorporating sexual functioning into a client’s overall wellness rather than only addressing sexuality when there is suspicion of dysfunction.

Purpose of the Study

The purpose of this phenomenological study is to investigate the meaning and language that counselors attribute to the construct “sexuality” and “sexuality counseling” from a social psychological constructivist perspective. Exploring the lived experiences of counselors regarding the provision of sexuality interventions will give insight into the dialectical experience of providing those interventions. To date, research has been focused on quantitative or philosophical inquiry (Parritt & O’Callaghan, 2000).

To access the meaning that counselors attribute to sexuality, it is essential to examine the language used to express the construct. Research questions were developed to determine how counselors experience sexuality from a personal and professional

perspective. The specific research questions that I will seek to answer from a social psychological constructivist perspective are:

1. What language and meaning to counselors attribute to sexuality?
2. What influences the language/meaning counselors attribute to sexuality?
3. Based upon counselors' lived experience, how is sexuality experienced in the counseling process?
4. What implications do these meanings have for Counselor Education and training?

The researcher's goal is to identify themes in the conceptualization of sexuality and sexuality counseling with the intention to highlight areas of concentration for future training and research and provide a basis for developing a wellness-based model for sexuality interventions.

Significance of the Study

The current study is significant in that it offers three contributions to the existing body of research. First, this study provides information regarding the language and meaning attached to the construct "sexuality" in counseling. Second, this study increases awareness and insight regarding counselor experiences regarding the impact of their perceptions on providing sexuality counseling to clients. Finally, this study provides an opportunity to make recommendations for the improvement of sexuality training practices in Counselor Education programs.

The language and meaning associated with sexuality in counseling is significant in clarifying the professional stance as it relates to the human sexual experience, which in turn provides a basis for conceptualizing the role of sexuality in the counseling process,

how to assess sexual functioning in clients, the most appropriate counseling interventions with regards to sexuality, and the role of counselors in addressing the range of sexual concerns with which clients may present. It is also important to identify how counselors' personal experiences impact their conceptualization of clients' sexuality from an ethical perspective to ensure that no harm is being inflicted on clients as a result of counselors' personal views.

Much emphasis is placed upon self-awareness in counselors. Understanding counselors' perspectives of their sexuality interventions with clients is significant in assessing the needs of counselors related to sexuality training and supervision. When sexuality is not discussed extensively in counselor education programs or in supervision, it is less likely that counselors will then address sexuality with clients. Creating a dialogue about the role of sexuality in counseling can assist counselor educators and supervisors in developing ways to incorporate sexuality into discussions with counselors.

Finally, determining where on the wellness-dysfunction continuum counselors place sexual experiences is significant in determining whether counselor education programs should continue to teach counselors in training about sexuality based on DSM diagnoses and recommend referral for intensive interventions or if new sexuality training practices and competencies need to be developed within the counseling profession based upon a wellness perspective.

Overall, sexuality has not been addressed in the literature from the perspective of counselors, and the current study will begin a dialogue that raises additional research questions for further examination. Encouraging focus on counselors highlights the responsibility to advocate for the incorporation of sexuality into counseling with greater

intentionality and less stigmatization than presently exists. It further encourages a dialogue that negates waiting for clients to bring up their sexual concerns or immediately referring clients to a specialist, who will inevitably approach the sexual concern from a medical rather than a developmental perspective.

Definition of Terms

Dialectic—A method of argument or exposition that systematically weighs contradictory facts or ideas with a view to the resolution of their real or apparent contradictions (American Heritage Dictionary, 2012)

Medical Model—The traditional approach to the diagnosis and treatment of illness as practiced by physicians in the Western world since the time of Koch and Pasteur. The physician focuses on the defect, or dysfunction, within the patient, using a problem-solving approach. The medical history, physical examination, and diagnostic tests provide the basis for the identification and treatment of a specific illness. The medical model is thus focused on the physical and biologic aspects of specific diseases and conditions (Mosby's Medical Dictionary, 2009)

Sexuality—a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, relationships, and so on. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors (World Health Organization, 2012).

Sexual Dysfunction—The disruption of sexual functioning, defined as the ability to experience desire, arousal, orgasm, and satisfaction. Primary sexual dysfunction has always been a difficulty, and secondary sexual dysfunction is a problem that emerged at some point (Bradley & Fine, 2009).

Sexuomedicalization—The medicalization of sexuality (Tiefer, 2010)

Medicalization—The complex process of transforming a social situation or personal experience, especially one that is culturally abnormal or ‘deviant’, into a medical problem that requires treatment by medical experts (Tiefer, 2010)

Wellness—the merging of body, mind, and spirit, with an emphasis on a balanced life-style as both a process and a goal (Myers, 1991)

Organization of the Study

As the meaning of sexuality is created and maintained by the language agreed upon among counselors within the Counseling profession, it is not surprising to observe a dialectical dilemma within the profession between sexual dysfunction and sexual wellness, perpetuated by the adoption of the DSM and exacerbated by sexuomedicalization in the United States. Although attempts have been made to reframe the use of the DSM through introducing alternative interpretations of diagnoses or to reject the medical model in favor of a wellness model, counselors’ meaning of sexuality remains unclear. This study will seek to use a social psychological constructivist perspective to conduct a qualitative study with a phenomenological design to examine counselors’ perceptions of sexuality and sexuality counseling through the language they use. Chapter 2 will provide an expanded exploration about the literature on sexuality counseling. Chapter 3 will include an explanation of the research design method used.

Chapter 4 will be a report of the results, and chapter 5 will include a discussion of the implications of the study for counselor education, training, practice and future research.

CHAPTER II

LITERATURE REVIEW

A dialectical dilemma has existed between the medical model and wellness-based approaches to mental health care provision, with sexuality being a recipient of the consequences (Beasley, 2008; Diamond & Huebner, 2012; Elders, 2010; Myers & Sweeney, 2005, 2008; Nosek, et al, 1994; Swarbrick, 2006; Tiefer, 2010). Although the counseling profession had adhered to a wellness-oriented philosophy, it has remained loyal to the language imposed by the Diagnostic and Statistical Manual (Bradley & Fine, 2009; Dougherty, 2005; Smith & Robinson, 1995; Southern & Cade, 2011; Wampold et al., 2001; Zalaquett et al., 2008). The medicalization of sexuality has contributed to the determination that sexuality is a specialization in counseling (Nasserzadeh et al., 2009; Southern & Cade, 2011), in spite of affirmation of sexuality's developmental nature (Diamond & Huebner, 2012; Elders, 2010; Fyfe, 1980; Gill & Hough, 2007; Southern & Cade, 2011; Trimble, 2009). As a result, efforts to increase training regarding sexuality in Counselor Education programs have not resulted in significant changes in programming (Fyfe, 1980; Paiva, 2005; Trimble, 2009), and little has been presented about how counselors conceptualize sexuality and sexuality counseling and incorporate it into practice (Hays, 2008; Parritt & O'Callaghan, 2000).

In this chapter, the definitions and standards of sexuality, sexuality counseling, and training will be explored within the context of medical and wellness model perspectives, with an emphasis on the language and meaning attributed to sexuality. Also,

the movement toward a constructivist perspective of sexual wellness will be highlighted. This chapter concludes with a summary of the language and meanings attributed to sexuality in the counselor and counselor education literature.

Conceptual Models of Sexuality

While the definition of sexuality and sexuality counseling has been unclear across disciplines, perspectives of sexuality can be viewed along a continuum between the medical and wellness models. Specific definitions, standards, and interventions of sexuality counseling have been based upon where on the continuum sexuality is placed, indicated by the language used by professionals, both influenced by and an indicator of attitudes about sexuality (Beasley, 2008; Lazarus, 2008; Paiva, 2005; Prawat, 1996; Tiefer, 2010).

In the United States, the presentation of wellness and medical models of health have appeared to contradict rather than complement each other, with the medical model pre-dating wellness approaches in service provision (Bullough, 1975; Gladding, 1992). In Psychology, Counseling's "mother discipline," (Urofsky & Engels, 2003, p. 126), the language used to conceptualize sexuality was established by the Diagnostic and Statistical Manual of Mental Disorders (DSM), originally identified as sexual deviation, including sexual immaturity, sex offenses, and sexual perversion (APA, 1952). The second edition of the DSM expanded the categories of sexual deviation to include homosexuality, fetishism, pedophilia, transvestitism, exhibitionism, voyeurism, sadism, masochism, and other sexual deviations (APA, 1968). The third edition of the DSM included a shift from sexual deviations to Psychosexual Disorders (APA, 1980). Psychosexual dysfunctions outlined a perception of deviant sexual experience based

solely upon “dysfunction” as determined by Helen Singer Kaplan’s adaptation of the sexual response cycle observed by Masters & Johnson (APA, 1980; Sexuality Encyclopedia, 2012). The counseling profession adopted the DSM as the standard for conceptualizing client concerns and structuring interventions to meet the demands of the United States’ mental health industry in the 1970s-1980s (Murray, 2006; Smith & Robinson, 1995). By doing so, the counseling profession also embraced the medical model, and therefore, its definition of sexuality. Many have asserted that the medical model is in direct contrast with the philosophy and values of the profession, which refuted the universal problem-centered approach (Urofsky & Engels, 2003) and expanded mental health services to include prevention and wellness (Myers, 1991; Smith & Robinson, 1995). From that point, the Counseling profession became enmeshed in a dialectical dilemma between emphasizing wellness and treating dysfunction, in which sexuality became entangled.

Perhaps the culmination of the vacillation between extreme views regarding sexuality in America throughout the country’s young history (Lazarus, 2008), there has appeared to be a recent emerging consensus across disciplines that sexuality is more complex than mere biological function (Bogey, 2008; Fyfe, 1980; Gill & Hough, 2007; Jackson, 2010; Lazarus, 2008; World Health Organization, 2012), with new conceptualizations of sexuality including both the physiology of and the meanings associated with sexual behavior (Bogey, 2008; Lazarus, 2008; World Health Organization, 2012). Although the complexity of sexual behavior has recently been acknowledged, there continued to be little clarity and agreement regarding a concrete definition of sexuality (Jackson, 2010; Tiefer, 2006), and most research on sexuality has

focused on dysfunction rather than health (Kleinplatz, et al., 2009; Lazarus, 2008) based upon research on American sexuality and sexual behavior conducted half of a century ago (Lazarus, 2008).

Defining Sexuality

Sexuality is more than what we do; it is a part of who we are. According to Long, Burnett, and Thomas (2006), sexuality could be defined as “an integral part of self-expression that is informed by our views of self, our sexual choices, our identification as male or female, and our physical selves” (p. 2). Many have agreed that sexuality is developmental in nature, with sexual expression differing between children and adolescents, which in turn differ from adults (Southern & Cade, 2011). Perhaps the largest influence on the developmental perception of sexuality could be attributed to Sigmund Freud, whose theory of psychosexual development provided a foundation for understanding the human psyche based upon his conceptualization of normal and abnormal sexual development across the life span. Although Freud was given credit for sexualizing mental illness, his work merely provided structure for the perspectives of his time and offered an alternative to the medical interventions that were being provided—the talking cure. Freud’s theory highlighted that when an individual acted on his/her sexual urges, there was an increase in both sexual interest and behavior, particularly in abnormal sexual behavior (Lazarus, 2008).

From a sociological perspective, sex is a social behavior, with norms being defined within a social and cultural context (Diamond & Hubener, 2012; Lazarus, 2008; Paiva, 2005; Southern & Cade, 2012; Trimble, 2009). In Western culture, the foundation of sexual values was based upon Puritanism, which promotes sexual expression within

the confines of a marital relationship, defined in America as the union between one man and one woman (Beasley, 2008; Jackson, 2010; Lazarus, 2008). Adhering to this ideal required that society placed significant effort on the promotion of defining sexual health and dysfunction within the scope of a binary perspective (i.e. male/female, heterosexual/homosexual, risk/safety; private/public) (Beasley, 2008; Lazarus, 2008).

The Social Learning Theory has asserted that sexual pleasure is a powerful reinforcer for engaging in sexual acts (Hogben & Byrne, 1998), with sexual behavior learned through conditioning (Hogben & Byrne, 1998; Petersen & Hyde, 2010; Sachs & Duffy, 1976) and sexual development influenced by parental behavior and interactions. The result of these conclusions was that sexuality “[could] be taught” (Hogben & Byrne, 1998, pg. 61). Influences on the social theories of sexuality have included Kinsey, Simon, and Gagnon. Alfred Kinsey’s descriptive survey of American male and female sexual behavior provided comprehensive information regarding the contrast between ideal American sexual values and the reality of American sexual behavior, challenging the binary sexual construct and demonstrating that American sexual expression fell along a continuum instead (Lazarus, 2008). His research provided valuable information for sexuality researchers to develop theories regarding sexuality (Hogben & Byrne, 1998). Gagnon & Simon’s research on sexual scripts highlighted the influence of culture on sexual expression by determining both the meaning associated with and the actions of sexual behavior (Lazarus, 2008; Simon & Gagnon, 1984, 1986). These authors’ findings negated previous notions that sexual behavior was predetermined by biological drives.

Recently, sexuality has been defined in holistic manner, including biology, psychology, morality, and social aspects (Bogey, 2008). Sexual stigmatization has led to

increased advocacy for the recognition of sexual rights and an emphasis on a more holistic approach to sexuality counseling that includes addressing social, cultural, and political influences on sexual functioning (Tiefer, 2010). Unfortunately, the sexual rights advocacy movements have largely focused on women's rights and lack gender neutrality in their criticisms of the medical model.

Medical Model and the DSM

The term “medical model” has been used in psychology to emphasize the belief that abnormal behavior should be addressed with medical interventions due to a biological cause (Bradley & Fine, 2009; Dougherty, 2005; Wampold, Ahn, & Coleman, 2001). Although its roots date back to Hippocrates' theory of imbalance in the four humours being the source of illness, the modern medical model was introduced in 1971 by psychiatrist Ronald Laing in response to criticism regarding diagnosing human behavior without sufficient physical evidence. From this model health was defined as “the absence of disease or infirmity,” and illness was measured objectively based upon a mechanical perspective of the human body. As the dominant model in the United States, medical research has largely relied upon this lens in the conceptualization of health (Dougherty, 2005; Larson, 1999; Peele, 2008; Wampold, Ahn, & Coleman, 2001). Overall, the medical model focus has been on the alleviation of symptoms (Tiefer, 2006; Zalaquett, et al, 2008), and interventions have five components: the presentation of a disorder/problem/complaint; an explanation of the problem in psychological terms; a warranted, theoretically-based psychological intervention; provision of a therapeutic intervention by a psychologist; and the attribution of the alleviation of the problem to the intervention (Wampold et al., 2001).

Several limitations have been identified in the medical model approach. The emphasis on deficiencies may overlook aspects of health. Focus on rapid stabilization may create bias in the assessment process, and the exclusion of spirituality omits a significant cultural influence on the conceptualization of problems. In mental health, the medical model perspective that therapy is “a pill” rather than recognizing the impact of the therapeutic relationship on change also minimizes the healing process while emphasizing the end result (Wampold et al., 2001).

In psychology, the structure of the medical model became standardized through the publication of the DSM in 1952. The initial DSM categorized specific types of pathological behavior patterns stemming from “mental health problems” based upon observations made in the military. Although revisions have occurred periodically since its original publication, the DSM has remained loyal to the medical model to conceptualize psychological complaints (Peele, 2008). Currently, the DSM-IV-TR is depended upon in a variety of mental health service delivery settings, often with payment for services contingent upon a DSM diagnosis generated from this text and medical model approach to treatment (Zalaquett et al, 2008). Due to the assumption that all disorders have a biological basis, symptom alleviation often includes psychotropic medications, at times in spite of conflicting or minimal evidence of effectiveness (Murray, Jr., 2006). As the Counseling profession expanded in its scope of practice beyond educational settings in the 1970s-1980s, it incorporated training based upon the DSM into training programs (Gladding, 1992).

In conflict with the mission statement of the Counseling profession, criticisms of the DSM also have included limited consideration for social and cultural influences on

mental dysfunction and an assumption that the behaviors outlined in the DSM are truly deviations from the norm without clearly defining the parameters of normality (Zalaquett et al, 2008). In addition, the symptoms outlined in each category are not mutually exclusive from each other, and the diagnostic process is not free of clinical subjectivity (Dougherty, 2005; Zalaquett et al, 2008), leading to susceptibility to abuse for the purposes of payment and accessing services (Dougherty, 2005).

Regarding sexuality, the emphasis placed upon a biological foundation of sexual dysfunction has been criticized for excluding social, cultural, and experiential influences on sexual expression (Tiefer, 2006). However, the shift of government funding from educational services to the military sector led to counselors competing in the mental health marketplace with social workers, psychologists, and psychiatrists (Gladding, 1992). Under pressure, counselors had to demonstrate proficiency in the existing language and conceptualization of the mental health arena in the treatment of mental illness (Myers, 1991). As a result, the Counseling profession incorporated medical model language, structure, and training into Counselor Education programs (Murray, 2006; Smith & Robinson, 1995; Urofsky & Engels, 2003). There has been some criticism of this decision as a significant shift away from the developmental roots of the profession (Dougherty, 2005; Urofsky & Engels, 2003). In spite of the fact that the ACA does not specifically endorse the medical model as the method of diagnosis and conceptualization in Counseling, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2001) began to require training in the current DSM (Dougherty, 2005). However, criticism of the medical model led the counseling profession to explore new conceptual models of intervention.

Sexuality and the Medical Model

The medical model has been infused into the conceptualization of sexual behavior for hundreds of years. As early as 1728, Hermann Boerhaave addressed the risks associated with excessive orgasm on men's health, infusing Christian theological bias into medical practice. The pattern of equating sexuality with illness has persisted since that time (Bullough, 1975). As sexuality accounts for approximately 30% of health care costs in the United States (Elders, 2010), the result of the impact of the medical model of sexuality has been the sexuomedicalization of American culture (Tiefer, 2002).

From the medical perspective, sexuality is a health concern, with an emphasis on alleviating disease, dysfunction, and disorder to regain a state of health and functioning (Bradley & Fine, 2009). Sexual function is defined as "the ability to experience desire, arousal, orgasm, and satisfaction" (Bradley & Fine, 2009, p. 76). This definition is based upon the sexual response cycle as defined by psychiatrist, Helen Singer Kaplan, a specialist in human sexuality who modified the cycle originally proposed by Masters and Johnson (Sexuality Encyclopedia, 2012). Her work served as the foundation for the sexual disorders outlined in the third edition of the DSM (1980) and was based on the physiological sexual experiences observed within the female and male partner in heterosexual couples in a laboratory setting (Nasserzadeh, 2009; Sexuality Encyclopedia, 2012). The DSM emphasized objective measures in diagnosing sexual dysfunctions, such as the amount of sex and details regarding physiological performance (Southern & Cade, 2011). In addition to symptom alleviation, the medical model of sexuality has focused on a quick resolution of undesirable symptoms through medication administration (Bullough, 1975; Southern & Cade, 2011).

Several criticisms have been published about the perspective of the medical model regarding sexuality. First, the focus on the physiological experiences of heterosexual couples omits social and cultural influences on sexuality (Southern & Cade, 2011), which is incompatible with recognizing sexual diversity and an expansion to conceptualizing sexuality as an aspect of a person's identity (Griffin, 1995; Tiefer, 2006). Second, only seven percent of sexual problems are actually shown to be due to medical factors. Additionally, medical interventions implemented for psychiatric symptoms cause sexual side effects, raising a question regarding the source of the sexual problems in that seven percent (Southern & Cade, 2011). Third, the medical model has a history of imposing stereotypes about sexual behavior that are perpetuated in spite of knowledge to the contrary, with sexual dysfunctions being viewed as more common in women than men (Bradley & Fine, 2009; Bullough, 1975). Criticisms have led to the introduction of alternative models of sexuality, such as the New View of Women's Sexual Problems, which takes into account biopsychosocial influences on sexuality (Southern & Cade, 2011; Tiefer, 2006). Even in the medical community, the perspective of sexuality has shifted from rigid adherence to physiological sexual functioning to perpetuate the human species to a social health behavior (Elders, 2010). Although sometimes criticized as being unscientific and insensitive to multicultural factors (Zalaquett, et al, 2008), the DSM became the standard by which mental health professionals continue to diagnose mental "dysfunction" and develop treatment in continue to diagnose mental "dysfunction" and develop treatment interventions (Peele, 2008).

As sex therapy became increasingly focused on using medicalized treatment approaches, counselors' discomfort in addressing sexuality with clients increased

(Bradley & Fine, 2009; Hays, 2008; Southern & Cade, 2011; Tiefer, 2006). Recent literature expressed disapproval of sexuomedicalization, with specific concerns raised in the dismissal of other contributing factors in sexual health and emphasis on short term resolution of the sexual “dysfunction” promoted by the pharmaceutical companies and managed care (Bradley & Fine, 2009; Southern & Cade, 2011; Tiefer, 2006). The discontent with medicalized conceptualizations of sexuality may be rooted in the historical emphasis on wellness rather than dysfunction in the counseling profession.

Sexuality and Wellness Models

In contrast to the very specific medical conceptualization of sexuality, wellness approaches have defined sexuality in broad terms, with some acknowledgment that it is a fundamental dimension of the personality (Fyfe, 1980) and includes all degrees of “ability, disability, and has many variations” (Gill & Hough, 2007, p. 75). Southern and Cade (2011) indicated that “sexual health represents more than the relative absence of symptoms, duress, or impairment” (p. 247) and that it “takes into account increasing opportunities to find fulfillment and make meaning from sexuality” (p. 247). Diamond and Huebner (2012) asserted that sexuality is a “health behavior with wide-ranging implications for mental and physical well-being” (p. 57). Other authors emphasized the impact of sexuality on overall wellness (Beasley, 2008; Paiva, 2005), as well as its overall complexity (Trimble, 2009). Considering the criticism of the medical model’s specificity and standardization of sexual experience, these explanations of sexuality from a wellness perspective are vague.

Wellness models have been inconsistent in their views of how sexuality fits into overall wellness, with four specific patterns of interest. First, like the medical model

perspective, wellness models have also defined sexuality as a couple experience with optimal sexuality viewed as involving intimacy between two partners (Kleinplatz, et al, 2009; Lazarus, 2008). Myers and Sweeney (2005, 2008) eluded to sexuality in their Indivisible Self model when they described the love aspect of the social self as involving intimacy. Sexuality in this model was undefined, yet assumed to include sexual activity based on the friendship aspect of the social self being described as involving the absence of sexual commitment. Therefore, the model insinuated that a difference between friendship and love is the level of intimacy/sexual commitment.

The second pattern regarding sexuality in wellness models was that sexuality was excluded as its own dimension of wellness. While both the Wheel of Wellness and Indivisible Self models of wellness included gender identity as one of their components of wellness, with the implication that androgyny is the highest level of functioning, sexual expression was not explicitly discussed as a noteworthy component in its own right (Myers & Sweeney, 2005, 2008). In Roscoe's (2009) description of the dimensions of wellness, there was an implication that sexuality was an aspect of the social realm and the physical realm. It was defined in terms of safe sex practices and the absence of disease, which contradicted the overall definition of wellness (Roscoe, 2009). Although Myers and Sweeney (2008) claimed that "studies on wellness represent every aspect of the entire life space," (p. 490), there was a deficit regarding the inclusion of sexuality, particularly in their own model of wellness. An example of how their wellness model simultaneously includes and excludes sexuality is an article outlining the promotion of the wellness approach with female sexual abuse survivors. Although the author specifically stated that sexual symptoms were a common experience of this population,

sexuality was not included in the assessment or treatment process (Hodges & Myers, 2010).

The third pattern regarding sexuality in wellness models is the emphasis on using this approach with women. As previously noted, the wellness model has been promoted for working with women with histories of sexual abuse (Hodges & Myers, 2010). This approach has also been suggested for implementation with women with disabilities as well (Parritt & O'Callaghan, 2000). There are currently no studies that examine this approach specifically applied to male sexuality.

The final pattern noted in sexuality in wellness models is the attempt to focus on sexual wellness while still maintaining loyalty to the medical model language and conceptualization of sexuality. Sexuality counseling has been perceived as a specific type of counseling that implemented only when the client enters treatment for a sexual *problem* (Southern & Cade, 2011). The new view of women's sexual *problems* is based upon the same concept. It was anticipated that the client would introduce a sexual problem rather than incorporating sexuality as part of a wellness assessment, using language that implied a positive experience and inviting clients to talk about their experiences. Furthermore, there has been an assumption that counselors need to "coexist with the medicalization of sex therapy for the benefit of our clients and our profession" (Bradley & Fine, 2009, p. 77). When criticisms have been raised about the medicalization of sexuality, the wellness argument becomes weaker upon emphasizing this benefit, particularly without exploring what that specific benefit is to clients and to the profession of sex therapy. The statement implied that counselors should not challenge the current status quo where it pertains to sexuomedicalization.

In the helping professions, there has been an increase in endorsement of a paradigm shift toward studying positive, normative, and pleasurable dimensions of sexuality and sexual functioning, with the perspective that sexual activity is a health behavior connected to overall well-being (Diamond & Hubener, 2012). However, the literature has simultaneously demonstrated a continued ethical struggle within the Counseling profession as efforts have been made to elevate its reputation as a science (Dougherty, 2005; Wampold, Ahn, & Coleman, 2001; Urofsky & Engels, 2003) that are reflected in addressing sexuality. Balancing maintaining courteous relationships with psychiatry and psychology with asserting the distinct professional values on which Counseling was founded led to a “more than” position (Smith & Robinson, 1995), in which counselors were expected to navigate the dialectical dilemma of treating sexual dysfunction while also helping clients attain sexual wellness. One lens from which to view the conflict, dialectical philosophy perceives that “opposing forces provide a rich environment for growth and change” as long as counselors are actively engaged in resolving the dilemma (Toporek, 2011, pg. 406). To resolve the inconsistent messages regarding sexuality and clarify the profession’s sexual values and efforts in providing effective sexuality counseling, discussion is needed with regards to counselors’ current perceptions of sexuality, stemming from their own personal histories, as well as societal and professional messages received (Gill & Hough, 2007; Hays, 2008; Rohleder, 2010; Tiefer, 2006; Toporek, 2011; Trimble, 2009; Weerakoon, Sitharthan, & Skowronski, 2008).

Sexuality Counseling

Sexuality counseling is currently viewed as a specialization (Southern & Cade, 2011) in spite of counselors acknowledging sexuality as a developmental experience. Because “counselors in both agency and school settings are repeatedly involved in counseling situations that involve sex-related problems” (Fyfe, 1980, p. 147), it is necessary to clarify the nature of sexuality counseling to determine what aspects are specialties and what aspects are, in fact, core competencies.

Defining Sexuality Counseling. Possibly because counselors view that sex is more personal than suicide, drugs, or death (Lazarus, 2008), sexual interventions have been a neglected part of the counseling process. Instead, sexual interventions became focused in the sex therapy discipline, with emphasis on medicalization and quick fixes (Southern & Cade, 2011). Whereas sex therapy is designed to address sexual dysfunction and dissatisfaction, sexuality counseling has come to be defined as focused on sexual satisfaction and optimal sexual functioning (Southern & Cade, 2011). Sexuality counseling is a cross-disciplinary term that describes any action aimed to provide sexuality interventions. Characteristics of sexuality counseling in the medical discipline involve the “promotion of sexual health” through client-centered, non-discriminatory discussions of sexuality that emphasize establishing a trusting relationship, paying attention to space, place, and context, communication, and cultural beliefs (van der Kwaak, Ferris, van Kats, & Dieleman, 2010). In counseling, sexuality interventions are expected to focus on emotional aspects of human sexuality (Fyfe, 1980).

Standards for Sexuality Counseling Training. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) established standards of training for counselors in 1981, with eight different areas of focused training and the relative absence of sexuality counseling training in counselor education programs (Dupkoski, 2012; Liles & Wagner, 2010). Training for issues related to sexuality have included addressing professional boundaries regarding sexual contact with clients in ethics courses; sexual minority issues in diversity-focused courses, and sexual disorders in assessment courses (Dupkoski, 2012). Within the specific counseling program areas of concentration, only marriage and family programs require a sexuality counseling course as part of masters' level training (CACREP, 2009).

Although sexuality training is incorporated into marriage and family counseling programs, the focus on sexual *problems* in the context of relationships and marriage neglects the sexuality of *all others*, including children, adolescents, and single persons. In spite of training being “irrefutably the first step in the acquisition of knowledge...[that] underpins professional competence” (Giami & Pacey, 2006, p. 267), it is not the knowledge itself that impacts counselors but how counselors “experience knowledge related to sex” (Trimble, 2009, p. 59). Without training, counselors are left to their own devices to develop the necessary skills to address sexuality with their clients.

The prevalent standard for sexuality counseling, training, and practice is outlined by the American Association for Sexuality Counselors, Educators, and Therapists (AASECT), the largest organization on credentialing guidelines and training (Gill &

Hough, 2007). In training, AASECT endorses the Sexual Attitude Restructuring (SAR) Model, originally developed by the Institute for Advanced Study of Human Sexuality in San Francisco, CA. This model involves systematic exposure to sexual material for the purpose of increasing awareness of one's sexual values and biases (Stayton, 1998).

AASECT also endorses a specific model for sexuality interventions, with specific roles and boundaries designated to sexuality counselors and sex therapists. AASECT endorses the PLISSIT model, which outlines a behavioral treatment protocol for sexual concerns based upon levels of competency, with specifications that sexuality counselors provide the first three levels and provide assessment and referral to sex therapists for the final level of interventions. In the first level, the counselor demonstrates comfort with the topic. At this level, permission is granted to clients to talk about sexuality ("P"). At the second level, the counselor recognizes sexual problems and provides limited information and education regarding sexuality ("LI"). At the third level, the counselor is able to evaluate sexual problems for intervention and referral, providing specific suggestions to clients to address sexuality concerns ("SS"). Should a counselor determine that sexual dysfunction is present through the assessment process, he/she would then refer the client to a sex therapist for level four, intensive therapy for severe sexual problems ("IT")

(AASECT, 2012; Southern & Cade, 2011). According to AASECT,

Sex counselors represent a variety of professions, ranging from medicine to the clergy. Examples of sex counselors are Planned Parenthood counselors, nurses and other health professionals, school counselors, and clinical pastoral care and counseling providers. Counselors assist the client to

realistically resolve concerns through the introduction of problem solving techniques of communication as well as providing accurate information and relevant suggestions of specific exercises and techniques in sexual expression. Sex counseling is generally short term and client centered, focusing on the immediate concern or problem (AASECT, 2012).

AASECT does not require master's level preparation for certification as a sex counselor, with masters prepared professionals not eligible for certification as a sex counselor and required to apply for certification as a sex therapist instead (AASECT, 2012). Therefore, a licensed professional counselor must become a certified sex therapist and provide interventions for sexual dysfunctions. The training for sex therapy certification includes: membership in AASECT, a master's degree plus two years of experience or a doctorate plus one year, professional licensure, human sexuality education, sex therapy training, attitudes and values training, clinical experience, and supervision (AASECT, 2012). Given the limitations regarding options for certification, the requirement that counselors treat sexual dysfunction may contrast with the perspective of viewing sexuality from a perspective of wellness, while highlighting the need to also understand the sex therapy discipline.

The current trend in sex therapy is to focus on medical interventions for sexual dysfunction. Sex therapy's emphasis on medical issues may ignore the systemic and relational issues, and underlying issues and opportunity to enhance sexuality and life satisfaction (Bradley & Fine, 2009). In addition, it continues to be unclear who is a sex

therapist and what they offer (Nasserzadeh, 2009). In spite of the training and standards provided by AASECT, more robust and systematic training requirements are recommended (Nasserzadeh, 2009; Southern & Cade, 2011). How a sexuality training program is designed is based on the definition of human sexuality (Bogey, 2008), with training manuals and protocol based upon treating dysfunction, trauma, and gender disorders (Bogey, 2008). Variations in training and biases/beliefs can lead to variation in mental health services and a tendency to avoid sexuality with clients (Gill & Hough, 2007; Jackson, 2010).

While one author stated that “sexuality counseling is a professional specialization in transition” (Southern & Cade, 2011, p. 247), ambiguity in defining the professional expectations and limits may also deter counselors from addressing sexuality with clients. Three conclusions result from the literature: Counselors do not feel competent addressing sexuality with clients; Counselors seem to agree that sexuality is more than biological; and Counselors demonstrate preference toward a perception of sexual health rather than dysfunction. To further understand these results, it is necessary to examine how this dialectical dilemma manifests itself in sexuality training and counseling.

Dialectical Dilemmas in Action

Many sexuality education programs in the community have relied upon a medical conceptualization to educate about sexuality (Giami & Pacey, 2006; Zwibelman & Hinrichsen, 1977). In these programs, the emphasis has often been placed upon physiology and risks of sexual behaviors (Beasley, 2008; Elders, 2010; Southern & Cade, 2011), whereas counseling researchers have emphasized focusing on sexual pleasure, surmising that doing so will lead to more egalitarian sexual practices (Beasley, 2008).

Alternatively, the medical approach to sexuality education has promoted safe sex practices without educating about sexual pleasure, an indicator of wellness, and abstinence without addressing relationship skills and alternative sexual behaviors (Beasley, 2008). In addition, sexuality education has often been termed sexual health while using language and techniques rooted in sexual dysfunction (Southern & Cade, 2011). Although some medical professionals have begun to promote a developmental perspective of sexuality, promoting abstinence contradicts the validation that “humans are sexual beings from birth to death” (Elders, 2010, p. 248).

The medical model has shown a significant influence on the perception of sexuality that perpetuates the wellness/illness dilemma. In society, pharmaceutical companies have influenced individuals to self-diagnose sexual dysfunction and seek medication while wellness counseling has intended to empower individuals to pursue their own wellness instead of highlighting dysfunction (Tiefer, 2010). In fact, there has been a normalization of sexual dysfunction (Murray, 2006), and teaching that less [sex] is better while the advertisements and media emphasize more sex (Diamond & Huebner, 2012). Although there has been an increased emphasis on promoting holistic perspectives and interventions for sexual concerns in the counseling profession, the literature has simultaneously excluded men from alternative perspectives of sexuality in spite of men being a primary target for sexuomedicalization (Tiefer, 2010).

Counselors have existed in a dialectical dilemma of balancing wellness approaches with the mandated medical model philosophy, with the dilemma providing “a rich environment for growth and change” (Toporeck, 2011, p. 406) as long as counselors are willing to accept the challenge. The Counseling profession has simultaneously offered

opposing endorsements of wellness/prevention and mandated diagnostic training based on the medical model through the CACREP requirement to teach the DSM (CACREP, 2009; Dougherty, 2005). Although the wellness and medical models have appeared to be in opposition to each other, it is the language used to conceptualize sexual behavior that perpetuates the rift. Counseling could rectify this dilemma by developing a diagnostic manual of its own or other standardized alternative to the current case conceptualization from a wellness, developmental perspective. In the meantime, there is a need to further examine the language and meaning that counselors and counselor educators attribute to behaviors and interventions to move away from extreme positions into a new, more dialectical understanding of the illness/wellness paradigms.

Wellness as a Constructivist Perspective

Wellness models are inherently consistent with constructivist philosophy. To examine the overlap between wellness approaches and constructivism, constructivist philosophy will be described before exploring wellness as constructivism. Wellness as constructivism can be observed through meaning, language, and learning aspects of wellness.

Constructivist Philosophy

Constructivist philosophy asserts that knowledge is dependent upon the context in which it is created, communicated, and maintained and is the opposite of objectivism (Murphy, 1997; Warmoth, 2000). Constructivism has been particularly influential in education and training settings, due to its emphasis on the learning process. Social constructionist epistemology posits further that knowledge is not the property of the individual but the community in which it is created, known as a knowledge/discourse

community. From this lens, truth is established when a group of people agree on it as truth, which is communicated in turn through symbols such as language or art (Prawat & Floden, 1994). Thus, an individual may have an idea about a construct that would then assume different meanings based upon the social and cultural influence of the individual's discourse community. Discourse communities are fluid, fluctuating throughout an individual's life, beginning with the nuclear family unit, then to schools, peer groups, and larger communities. When an individual enters a new discourse community, "truth" will be re-negotiated based upon the interactions within that community. Due to technological advances in the modern and post-modern eras, discourse communities are changed more rapidly, leading to a "continuous" reinvention of the meaning of constructs (Warmoth, 2000). The reinvention process is observed through the negotiation of new language regarding the construct (s) of interest.

Language as Meaning in Constructionism

Whereas social constructionism is a theory that emphasizes that knowledge is determined by social arenas and psychological constructivism asserts that an individual actively constructs knowledge through learning (Yilmaz, 2008), social psychological constructionism emphasizes that all experiences and behaviors are linguistic in that the language attributed to the experiences is negotiated and agreed upon between the individual and the discourse community when it becomes reality (Prawat, 1996). Therefore, the only way to understand the language attributed to a construct is to engage in discourse about it.

The process of negotiating meaning through language is apparent within the medical model view of psychology in that "common language" was the motivator for the

creation of the DSM (Dougherty, 2005, p. 132). In contrast, the language in Counseling is significantly different, implying a wellness versus illness focus as seen in the use of the term “client” rather than “patient” (Smith & Robinson, 1995, p. 158). Such terminology implies a more egalitarian relationship in the counseling process, whereas medical model language perceives the client as “passive” and therapy as “the pill” (Wampold, Ahn, & Coleman, 2001, p. 269). Use of terms such as “client” communicates a perception of the client as an active participant in the healing process, essential to empowering behavioral change.

Rather than knowledge being power; language is power because it serves as a mold or container that shapes the way knowledge is presented and communicated (Prawat, 1996; Prawat & Floden, 1994). Through the negotiation process, there is power to influence individuals’ perceptions and beliefs about themselves and their experiences. While information is becoming increasingly available to the general public, there still exists privilege within the professional communities, medical and mental health, to use language and meaning to create an impact on clients/patients. It is significant then to recognize that the language that is used in research, practice, and training has two outcomes, regardless of its nature. Language “exposes our attitudes and beliefs” (Wampold, Ahn, & Coleman., 2001, p. 268) “within which participants, clients, and students are expected to respond” (Toporek, 2011, p. 411). As such, researchers, counselors, and counselor educators have a responsibility to be mindful of the language that is used to “highlight certain aspects of the representation while simultaneously downplaying those that might mislead or misinform” (Prawat & Floden, 1994, p. 45). The reason for this caution is rooted in the power of language itself, which has

traditionally had the potential to be used to take advantage of persons outside of the discourse community (Warmoth, 2000) and/or “to confuse and oppress, whether intentionally or unintentionally” (Toporek, 2011, p. 411). Unlike language utilized in the medical model, language used in wellness approaches is intended to empower clients.

Wellness and Constructivism

Wellness perspectives of counseling are consistent with constructivist philosophy for several reasons. First, the meaning attached to the word “wellness” is dependent upon the knowledge/discourse community in which it is created, with consensus that wellness includes “a state of complete physical, mental, and social well-being” (Roscoe, 2009, p. 216). How each aspect of that state is defined is determined within various discourse communities. For example, how much a person weighs is often an indicator of physical condition, which is one aspect of physical wellness. The meaning of weight is determined by social and cultural factors, which then influences how a person’s weight is interpreted. If the community connects more weight with fertility, then a higher weight would be an indicator of physical wellness in a sexual realm. If the community connects less weight with ability, then a lower weight would be an indicator of physical wellness in the physical realm. A dialectical dilemma would occur if a person has been exposed to both interpretations of weight, leading to an opportunity to create new meaning from these experiences. In this way, wellness can only be understood within the context of each individual’s experience in various discourse communities, making wellness a subjective construct (Roscoe, 2009). Social constructionist perspective posits that increased globalization actually encourages individual responsibility in the learning and meaning-

making process and limits privileged access to certain knowledge, such as within the medical and mental health fields (Warmoth, 2000).

Just as the interactions within and between various discourse communities impacts the truth and meaning of wellness for each individual, the dimensions of wellness proposed by different authors are related to and impacted by each other (Myers, Sweeney, & Whitmer, 2000). Participation in discourse communities leads to an agreement within that community regarding the existence and definition of each dimension through language. The meaning/language regarding each dimension, in turn, impacts the meaning and language attributed to the other dimensions. In this process, dialectical dilemmas would arise in the process of making meaning of each dimension both within and between dimensions that could lead to an opportunity for the creation of a new understanding of wellness for that individual. Likewise, future interactions in discourse communities could then trigger the same process to occur, as is the anticipation in wellness-based counseling.

In the United States, wellness has appeared as the antithesis of dysfunction/illness creating a dialectical dilemma in which counselors can remain stuck, just before a greater understanding that incorporates both paradigms takes place (Roscoe, 2009; Soloman, 1994). Social constructionism differs from objective views of knowledge that assert the knowledge exists in the world, accessed through a scientific method that extracts or controls subjectivity to allow access to the truth that exists (Warmoth, 2000). Given that the foundation of social constructionism is based upon refuting the traditional view of knowledge, dialectics are then invited as a means of creating new meaning rather than maintaining opposition, with one winning as the truth.

Inconsistencies in language create dissonance, and dissonance leads to fragmentation of professional identity, as well as complicating the training process for new professionals. When it is not known how counselors and counselor educators view important constructs, it becomes difficult to negotiate with other disciplines and advocate for clients and professionals. Wellness models are consistent with constructivist philosophy based on the subjectivity and emphasis on context in both perspectives. In contrast, the medical model is not compatible with either due to the focus on objectivity and standardization of meaning, knowledge, and diagnoses. With regards to sexuality counseling, it is pertinent to know if counselors are comfortable co-habiting peacefully in opposition with while using the language of the medical model or if counselors are open to alternative perspectives of sexuality.

Sexuality in the Counseling Profession

Although sexuality has been included in psychology since Freud's introduction of the psychosexual theory of development, sexuality in the Counseling profession has moved toward a constructivist perspective over the past several decades (Paiva, 2005; Southern & Cade, 2011; Tiefer, 2006, 2010; Trimble, 2009). It is necessary to explore the history of sexuality in mental health and counselors' movement toward viewing sexuality from a constructivist perspective.

History of Sexuality in Mental Health

Although sex therapy began with Freud, it was not called sex therapy (Lazarus, 2008). Based on Freud's psychosexual development model, the goal of psychotherapy was to assist clients (female) in becoming sexually mature adults, which was defined as the ability to experience orgasm during heterosexual vaginal intercourse (Bradley & Fine,

2009; Bullough, 1994; Southern & Cade, 2011). In the United States, several pioneers of sexology provided a foundation for the understanding of human sexual behavior (Lazarus, 2008). In the 1940s, Alfred Kinsey and his colleagues sought to collect information on the actual sexual behaviors of humans to compare with perceptions of normal sexual behavior and as a result, dispelled myths surrounding sexual behavior (Southern & Cade, 2011). Masters and Johnson followed with conducting extensive observational research on the human sexual response cycle in the 1970s and implementing co-joint therapy techniques to improve couples' sexual experiences (Southern & Cade, 2011). Later, this model was modified by Kaplan, which then provided the basis for the classification of sexual disorders in the DSM (Southern & Cade, 2011). In the 1990s, the term *sexual addiction* was coined, and the nature of sexual problems addressed in therapy shifted toward more compulsive sexual behaviors (Southern & Cade, 2011). Viagra was introduced in 1998, and medical treatment of sexual problems became more common (Tiefer, 2006, 2010). As sex therapy has become increasingly medicalized, counselors' comfort in addressing sexuality with clients has been negatively impacted by lack of competency in medical interventions and lack of training in addressing sexual concerns with clients (Bradley & Fine, 2009; Hays, 2008; Parritt & O'Callaghan, 2000; Southern & Cade, 2011). Certainly, the medicalization of sexuality has impacted the views of sexuality in mental health.

Current Views of Sexuality in Mental Health

Recent literature on sexuality counseling has indicated the necessity to encourage medical screening before providing counseling for sexual problem(s), which is then recommended to be implemented from a holistic perspective (Southern & Cade, 2011).

During the interview regarding sexual problems, researchers have emphasized two specific aspects. It is essential to assess for sexual abuse, sex-negative, and family of origin messages related to sex in impacting current sexual functioning. In addition, use of scaffolding in sexuality counseling is recommended. Scaffolding involves exploring the knowledge currently possessed by clients, reviewing the context in which new sexual information is to be learned, enhancing motivation to learn and practice new information, and finally, presenting new information to clients about sexuality (Southern & Cade, 2011).

As women's sexuality is particularly emphasized in recent literature, it is recommended that women be allowed to define their own sexual problems based on psycho-bio-social aspects of sexuality (Tiefer, 2010). As an alternative to the medical model, "The Campaign for a New View of Women's Sexual Problems" was introduced in 2000, a social constructionist perspective on sexuality (Southern & Cade, 2011; Tiefer, 2006). It was created for two reasons: to serve as a watchdog for pharmaceutical companies and to educate the public and professionals about the limitations of the medical model (Tiefer, 2006, 2010). The alternative lens of women's sexual problems views a sexual problem as "a discontent or dissatisfaction with any emotional, physical, or emotional aspect of sexual experience" (Tiefer, 2010, p. 204) that may present itself in one of four areas: sociocultural, political, or economic factors, partner or relationship, psychological, or medical. These four areas are then broken down into sub-areas for further elaboration.

Constructivism in Sexuality Training

In spite of the current recommendations for sexuality interventions, the discomfort that counselors experience in discussing sexuality with their clients, connected to a lack of education, training, and supervision in this area, lends itself to the interventions not being initiated or sexuality being explored comprehensively enough to assist clients in achieving sexual wellness (Hays, 2008; Parritt & O'Callaghan, 2000). As counselors serve as models for their clients regarding how to approach their presenting concerns, clients may also experience increased shame regarding their sexuality and therefore be less likely to initiate the conversation themselves. The impact of the counselors' personal and professional experience with the topic sexuality points to the pertinence of sexuality training, both in graduate and post-graduate settings, to increase both counselors' confidence and competence.

The common thread among social constructivists is the premise that knowledge is a social product communicated through language (Prawat & Floden, 1994).

Constructivism has been a noted theme within the literature related to sexuality in counselor education, particularly in sexuality training (Bogey, 2008; Fyfe, 1980; Tiefer, 2006). Paiva (2005) introduced the term "sexual socialization" (p. 346) to refer to the process of sexual behavior being impacted by social setting and cultural context and extended the identification and definition of this process by recommending the use of sexual scenarios and stories to access and understand the social and cultural contexts of sexual behavior. Trimble (2009) postulated, from a critical constructivist perspective, that the meaning behind sexual behavior may make it difficult to prevent the behavior, while

then emphasizing the importance of knowing how individuals experience knowledge related to sex through the body rather than outside of it.

In spite of the emphasis on social and contextual factors, subjectivity, and meaning associated with sexuality, sexuality training has not been required in counselor education programs, with the exception of marriage and family programs (CACREP, 2009). In these programs, the focus has been on sexual problems within the marital/relationship context, neglecting the sexuality of individuals, adolescents, and children (CACREP, 2009) and has not necessarily been viewed as sufficient preparation for clinical practice by marriage and family therapists (Hays 2008; Parritt & O’Callaghan, 2000). Diagnosing sexual concerns based on DSM sexual disorders—created from observations of the sexual response of heterosexual couples-- may reinforce a dysfunctional and heterosexist perspective of sexuality in Counselor Education programs (CACREP, 2009).

While some advances have been made in understanding human sexual behavior within the medical model, these advances were largely based on physiology and performance rather than fulfillment. A similar pattern of focusing on dysfunction has persisted in counseling, and although a course on sexuality counseling has been incorporated in marriage and family counseling programs, school counselors and mental health counselors have been excluded. As the meaning and language regarding sexuality continue to shift, it is essential to explore the conceptualization of sexuality in counseling.

Sexuality, Language, and Meaning in Counseling

As members of our own unique and shared discourse communities, counselors are influenced by societal and cultural messages regarding sexuality prior to, during, and after professional training. The result is in an inevitable impact on the language and meaning that each counselor places on sexuality, which in turn have an unavoidable impact on clients and other professionals as continued members of discourse communities. To examine this influence, it is necessary to explore language, meaning, and counselors' responses as they are presently understood.

Language

Historically, the language to discuss sexuality has been viewed in terms of normality and abnormality, with some sexual behaviors that are deemed to be stuck in the midst of dialectical dilemmas, such as “consensual sexual violence” versus sexual assault (Beasley, 2008, p. 155) or kinky versus deviant. Predominantly, however, sexuality has been discussed, diagnosed, and normalized within the context of heterosexual couple sex (Southern & Cade, 2011). In addition, opinions of heterosexual sex have traditionally conveyed a message of danger in Western society, such as prostitution, rape, and pornography, as well as instilling a belief that men are more prone to be predators, while women are perceived as vulnerable (Beasley, 2008). The goal of sexuality education is, then, to teach people to be “good sexual citizens” (Trimble, 2009, p. 53). The sexual stigmatization occurring through the influence of social and cultural factors on sexuality

has led to an increase in advocacy for sexual rights and an emphasis on social, cultural, and political influences on sexual functioning (Tiefer, 2010).

Recognizing the influence of the language used to create, communicate, perpetuate, and alter the meaning associated with sexuality, efforts to impact the philosophy of sexuality training and research must begin with an exploration of the language used to express the construct (Elders, 2000). Framing sexuality in terms of dysfunction has an inevitable impact on the meaning counselors place upon sexuality, particularly as that language is then communicated to clients (Beasley, 2008). Changing language from an emphasis on the dangers of sex to sexual pleasure is believed to lead to more egalitarian sexual behaviors and is consistent with wellness-based approaches.

In relation to how the language and meaning associated with sexuality have influenced counseling practice, there is a tendency for counselors to avoid uncomfortable topics (Gill & Hough, 2007; Hays, 2008; Parritt & O'Callaghan, 2000). Because detachment is not possible in counseling, it is important to understand counselors' meaning and language regarding sexuality to have insight into the meaning regarding sexuality that is created within the counseling process because it has an impact on clients (Urofsky & Engels, 2003).

Counselors' Language and Meaning of Sexuality

There has been a tendency in the Counseling profession to view sexuality as a specialization or special topic rather than a core competency (Gill & Hough, 2007;

Nasserzadeh, 2009; Southern & Cade, 2011). Viewing it as a special topic may lead to decreased general training (Parritt & O’Callaghan, 2000; Southern & Cade, 2011).

Alternative perspectives of sexuality counseling consistent with constructivist philosophy are beginning to show themselves in the literature, with postmodern sex therapy emphasizing the meaning that people make of their sex lives and a recognition in the subjectivity of assessing sexual problems in counseling (Gill & Hough, 2007; Southern & Cade, 2011). This shift in meaning associated with sexuality in counseling encourages counselors to “advocate sexual authenticity and sexual entitlement without hiding behind the medical model of sexual health and normality” (Tiefer, 2010, p. 371) and to “be mindful that sexuality can exist under all circumstances within a variety of expression, some known and some not known” (Gill & Hough, 2007, p. 75). If sexuality is viewed as both a right of clients and a universal experience, sexuality would then be an area in which all counselors would need basic competency to meet the needs of clients.

Criticisms of the current sexuality training and practices in Counseling include the omission of children and adolescents in spite of stating that sexuality is natural and life-long (Southern & Cade, 2011) and the focus on defining sexuality within the context of heterosexual couple relationships (Bradley & Fine, 2009; Diamond & Huebner, 2012; Southern & Cade, 2011).

Counselors’ perceptions of sexuality are influenced by societal and cultural messages and experiences as a result of their own unique combination of discourse communities. Views of sexuality in counseling appear to be “stuck” in a dialectical dilemma, with traditional views of sexuality dominating the discourse at present. Recently, the literature has been communicating a call to shift counseling’s view of sexuality and change the

language used to express the construct. However, it is uncertain at this time if there is a consensus in counseling about sexuality and how to assess and address sexual concerns from a perspective consistent with counseling values, given the reliance upon the medical model terminology. The current study will clarify counselors' views and meaning of sexuality while also assessing the language used as an indicator of the status of the dialectical dilemma between wellness and illness based perspectives.

Summary

Opposing wellness/illness paradigms in conceptualizing and addressing sexuality with clients saturate the literature, with a current dialectical dilemma apparent. Theoretical literature has demonstrated a shift toward a constructivist perspective of sexuality and emphasized the need for sexuality training. However, there continues to lack a conceptualization of sexuality in counseling that is balanced. As empirical research in sexuality counseling is lacking, suggestions have been made to conduct research on sexuality in counseling and to clarify the meaning associated with sexuality in counseling. The current study aims to use a phenomenological approach of qualitative inquiry to obtain insight into counselors' perceptions of sexuality through the language they use. Chapter Three will include details to the study methodology.

Chapter III

METHODOLOGY

Chapter Two provided an overview of literature relevant to the current study and included a discussion of the relationship between wellness and medical model perspectives in counseling as it related to the definition and meaning of sexuality in counseling. In addition, the literature highlighted deficits within both of the paradigms in the conceptualization of sexuality and emphasized the need for additional research to clarify sexuality in counseling. With most of the literature reflecting philosophical perspectives of sexuality and emphasizing the need for sexuality training, there has not been a qualitative study to date that has focused on the meaning that counselors attribute to sexuality. In this chapter, methodology of the current study, including detailed discussion of the context, design, participants, researcher's role, ethical considerations, data collection methods, focus group questions, and data analysis is discussed.

The current study is best explored, as suggested in the literature, by qualitative inquiry. Qualitative research “seek[s] to make sense out of actions, narratives, and the ways in which they intersect” (Glesne, 2011, p. 1) without relying upon objective research design measures. Specifically, qualitative research emphasizes building rapport to collect the most reflective data of the phenomenon under investigation and increase the reliability of both the information and observations. The objective is accomplished by engaging in various techniques, such as triangulation and member checking. According to Maxwell (2005), there are five specific goals of inquiry for which qualitative research

is appropriate: “understanding particular meaning, understanding particular context, identifying ‘unanticipated phenomena and influences,’ understanding process, and developing explanations based on cause” (pp. 22-23). To warrant qualitative methodology, these goals may be mutually exclusive but are particularly relevant to the current study. The purpose of this study was to identify current themes in the construct of sexuality reported by counselors and use insight gained to recommend improvements regarding sexuality training. Such intention clearly identifies a goal of understanding the *meaning* of sexuality within the *context* of counseling, to include the *process* of defining the construct in the counseling community, with the ultimate goal of *explaining* the cause of the unclear definition through a social psychological constructivist lens. This theory was most appropriate due to its emphasis on the role of language in creating meaning (Prawat, 1996; Prawat & Floden, 1994). In the proposed study, the language used to express the construct “sexuality” was accessed through counselors (individual) within the counseling profession (discourse community) using an interpretive phenomenological research approach. To accomplish this goal, a synchronous online focus group and two individual interviews were conducted, a non-traditional but dialectical format (Bradbury-Jones, Sanbrook, & Irvine, 2009; Palmer, Larkin, deVisser, & Fadden, 2010).

Research Questions

To explore current themes in counselors’ conceptualization of sexuality, the selection of research questions was essential to gaining access to the language and meaning associated with sexuality for participants. This information was compared between participants, who represented different counseling specialties. Questions were developed to highlight the meaning of sexuality to counselors, using language as the

focus of analysis. Therefore, although the research questions were specific regarding what is being analyzed, the questions posed to the participants were intended to be vague to minimize the impact of the researcher's own language and allow flexibility in participant responses. The specific research questions that I sought to answer from a social psychological constructivist perspective are:

1. What language and meaning to counselors attribute to sexuality?
2. What influences the language/meaning counselors attribute to sexuality?
3. Based upon counselors' lived experience, how is sexuality experienced in the counseling process?
4. What implications do these meanings have for Counselor Education and training?

Participants

Qualitative research relies on purposeful rather than random sampling methods to increase the depth of information accessed by the study rather the generalizability of results (Patton, 2002). Due to the nature of the proposed study, stratified purposeful sampling was conducted to accommodate the necessary steps to recruiting participants. This stratified purposeful sampling approach involved two other forms of sampling—criterion and chain referral (snowball) sampling.

Criterion sampling was conducted to access the pool of participants. Participants were selected based on the following criteria: having earned a master's degree in a counselor education program in one of three areas of concentration (school counseling, clinical mental health/community counseling, and marriage, couples, and family counseling), current licensure in state of residence, and having experience addressing

sexuality with more than one client. These criteria were essential to the study in that they guaranteed consistency in minimum training requirements and allowed examination of the construct of sexuality before, during, and after counselor training. Once these criteria had been established, participants were accessed using chain referral sampling techniques. These sampling techniques were appropriate and necessary in the construction of focus groups (Patton, 2002), given the need to recruit participants who represent particular characteristics of interest to the study.

An initial attempt was made to recruit participants in the community/clinical mental health counseling and marriage, couples, and family counseling concentrations by accessing the therapist directory on the Psychology Today website (http://therapists.psychologytoday.com/rms/prof_search.php) and emailing therapists who met the basic criteria of the study to invite them to participate. Participants from the school counseling concentration were attempted to be recruited by posting an invitation through the American School Counselor Association (ASCA) website (<http://www.schoolcounselor.org/>). In all invitations, a link was included to a website (www.surveymonkey.com), which included a demographic survey to screen for specific selection criteria. After several months of attempting to recruit via this method without success, chain referral sampling was implemented. An email outlining the criteria and an invitation to participate in the study was submitted to known contacts of the researcher to then submit to professional counselors with whom they were acquainted. These emails included a link to a website (www.surveymonkey.com), as previously indicated. Proposed participants could have been located anywhere in the United States, provided they met the above criteria. They may have identified as male or female, and although

this information was known by the researcher, each participant had the option to decide whether to disclose this information to the group, given the anonymity provided by the online site construction. In addition, it was hopeful that there would be within-group diversity to provide for a more dynamic discussion related to the topic of interest. Again, disclosure of demographic information was the decision of each individual participant. Regarding years of experience, it was anticipated that variation would exist in this area as well.

Procedure

As consistency in the conceptualization and definition of sexuality has been lacking in the counseling profession, a phenomenological approach was implemented to explore the construct of sexuality from counselors' perspectives. Although phenomenological approaches have not been used traditionally in focus groups, there is increasing literature affirming that phenomenology is not inconsistent with focus group research format (Bradbury-Jones, Sanbrook, & Irvine, 2009; Palmer, Larkin, deVisser, & Fadden, 2010). In fact, these studies highlight the complementary aspects of combining these approaches to provide additional information beyond what can be gathered from focus groups and phenomenological interviews alone. Additionally, a phenomenological approach can assist with balancing the individual's experience with the experience of the group process, accounting for both aspects of the construction of meaning. Furthermore, there have been subjects and occasions where the experience of the individual has been described in richer detail within the group process. Particularly in an online format, where more individualism is maintained than in a traditional focus group, a balance was

anticipated to be attainable in accessing these two perspectives by using a phenomenological design.

A phenomenological approach was best suited for the current study over other methods due to the necessity to explore a phenomenon—sexuality—that does not currently have a clear, consistent definition within the counseling context. Given the lack of definition of the construct, it was necessary to understand its meaning prior to developing a theory regarding its role and function in counseling. Further, a narrative approach would not have necessarily focused specifically on the language and meaning associated with sexuality counseling, and other theoretical frameworks would have proved difficult as well without some concept of the meaning associated with sexuality.

Data Collection

Several factors were included in data collection, including ensuring the confidentiality of participants, collecting data in a manner relevant to the research questions posed, and the manner in which the data was collected, to include location of, collection, and storage of data. The collection method of participation of an online discussion in a focus group format was consistent with this genre of research and was the most appropriate method of data collected due to the sensitivity of the subject matter, greater likelihood of anonymity, and focus on language as the method of accessing the meaning associated with sexuality in counseling (Hanley, 2011; Kenny, 2005; Reid & Reid, 2005; Stancanelli, 2010; Stewart & Williams, 2005). An online focus group format was selected due to the opportunity for participants to reflect on the questions and provide initial responses, changes to responses, and additional responses to each question without the constraints of the traditional focus group format, such as the influence of

social cues, competition for response time, and allotted time for the focus group interview (Hanley, 2011; Kenny, 2005; Reid & Reid, 2005; Stewart & Williams, 2005).

Furthermore, online focus groups lead to an increase in willingness to challenge each other's perceptions due to the perception of anonymity and psychological distance (Stewart & Williams, 2005). Increased likelihood of challenging perceptions and responses was anticipated to provide a richer discussion of the phenomenon under examination. In addition, participation in a focus group provides an opportunity to examine both individual responses and the meaning construction within the context of a discourse community.

One of the strengths of online focus groups is related to the number of participants that can be accommodated. Online focus groups not only can accommodate more participants than traditional focus groups, research has shown that fewer participants results in less investment in participation (Hanley, 2011; Kenny, 2005; Stancanelli, 2010; Stewart & Williams, 2005). As such, the current study was open to between 5-10 participants. An increased number of participants was anticipated to result in additional information and additional investment in study participation by participants.

The study took place through the facilitation of an online focus group discussion and two individual interviews. The site was not comprised of a physical location but rather a designated website accessed at the participants' convenience. The decision to opt for an online format rather than a traditional focus group format was based on several factors. First, the emphasis on the language/words used to describe sexuality was considered of primary importance to the study, particularly the language/words negotiated within a particular discourse community. Therefore, an online discourse would

provide more focus on the language/words without the impact of non-verbal communication and interactions that could present in a traditional focus group format (Hanley, 2011; Kenny, 2005; Reid & Reid, 2005; Stancanelli, 2010; Stewart & Williams, 2005). Second, given that sexuality is sensitive subject, an online focus group could provide buffers against inhibitions regarding self-disclosure, such as a psychological distance from the group members and a perception of anonymity (Reid & Reid, 2005; Stancanelli, 2010; Stewart & Williams, 2005). Third, constraints related to sampling based on convenience were anticipated to be minimized by structuring the focus group through an online format to expand the potential pool of participants outside of the region in which the researcher is located. The removal of geographical limitations could provide richer information related to the construct of interest (Hanley, 2011; Reid & Reid, 2005; Stancanelli, 2010; Stewart & Williams, 2005). Fourth, use of the online format was also warranted due to the auditory impairment of the researcher; online focus groups can be visually confirmed and printed, reducing potential error in the transcription process and increasing the trustworthiness of the data. Factors in the site selection process included ease of navigation both for the facilitator and participants, cost, and security.

Data was collected via a secure internet conferencing and networking site (www.24im.com), for which participants attained access using a code provided by the researcher. After considering sites based on these criteria, the “24im” site (www.24im.com) was selected for this study due to meeting a specific set of requirements. In addition, participants were not required to provide an email address to participate in the site. Instead, each participant was given an access code/link by the facilitator. Not being required to provide an email address provided an additional sense of

anonymity, has shown to be an important factor when conducting focus groups on sensitive subjects (Reid & Reid, 2005; Stancanelli, 2010; Stewart & Williams, 2005). Finally, the selected site was a free service for both the facilitator and the participants.

The 24im site required a code to log on for participants. Figure 1 shows a screen shot of a potential 24im chat window page. Both participants and the facilitator could provide a username instead of their given name. The site was available during the scheduled time of the interview/focus group for the participants. Participants were able to email the facilitator with questions or concerns related to the site.

Figure 3.1: 24im site screenshot



No other person was able to access the site without the password. The researcher acquired data from the participants' online responses to discussion/interview questions provided during either a one hour individual interview or a two hour focus group discussion. Collection involved copying the questions and responses into a Microsoft Word document verbatim and in the order of entry following the interview/focus group. Once pasted into a Word document, the transcriptions were then saved in Dropbox, a secure, web-based online storage service that is password protected. Storing the files in this location ensured that the data would not be lost due to computer system error and

could not be accessed by anyone other than the researcher(s). To protect the confidentiality of participants, several methods were implemented, including the use of password protected websites and storage service, the ability for each participant to select their own username and decide what information to disclose to the focus group, and opportunity for private discussions with the researcher through private email correspondence.

A link to access a demographic interest survey (Appendix A) from www.surveymonkey.com was provided to potential participants via email contact, accessible for all types of counselors of interest, allowing two to three months for interested persons to respond. Participants meeting the specific criteria were then invited to participate in the online focus group through email correspondence, in which an invitation letter (Appendix B) and informed consent (Appendix C) were provided. In a follow up email, a password/link to access the site and instructions (Appendix D) was provided for each consenting person. Rapport was established with the participants through private email correspondence to invite questions regarding the study.

Synchronous discussion was facilitated with participants who were able to attend a scheduled time, and individual interviews were conducted with participants unable to attend, using the same online format. Each interview question was answered through the 24im website, with the exception of one question via email due to a participant needing to leave the focus group prematurely. The focus group discussion took place over a two hour time period and included six interview questions. Individual interviews took place over a one hour time period and included the same six interview questions. An additional

advantage of the online focus group format involved the opportunity for participants to add their own questions to the discussion.

Ethical Measures to Protect Participants

To protect the confidentiality of participants, several measures were taken, to include protecting names and data throughout the research process. First, demographic information for the participants was requested for the purpose of initial selection. This information was used to contact the participant for the purpose of initiating the study and contacting participants at the conclusion of the study to communicate appreciation and offer an opportunity to review the transcription for accuracy. The information was stored in a secure, password-protected email and online storage database, accessed only by the primary researcher. Second, participation in an online focus group assured confidentiality in two ways. Participants' confidentiality was maintained through the use of an anonymous format in data collection and reporting. In particular, the participants were permitted to use their initials rather than their actual name. In addition, the participants did not have to provide an email address to access the web-site. Third, the participants were referred to in the transcript and final report by their initials and a pseudonym rather than their actual name. Finally, participants were not be asked to disclose any identifying information about themselves beyond what they were comfortable sharing.

Focus Group Questions/Instrumentation

Following recruitment, participants were provided with additional information regarding the purpose and format of the study through a letter of invitation to participate in the study and an informed consent. In addition, informed consent was implied at several points in the study, to include: responding to the invitation to participate by

logging onto the site, posting responses to the site, and answering the question: “Why are you interested in participating in this study?” (Kenny, 2005). Participants were expected to log on to the focus group/interview at the scheduled time and respond to each question accordingly. Questions that were posed during the study included:

1. How would you define “sexuality”?
2. Talk about a recent experience you had providing counseling when sexuality came up.
3. How does your definition of sexuality impact your work with clients/students?
4. What influenced your perspective of sexuality?
5. Compare your current perspective of sexuality to before you became a counselor.
6. Describe your thoughts about sexuality counseling/training.

These questions allowed two constructs of interest to be observed: each individual participant’s lived experience of sexuality and how the group negotiates meaning regarding sexuality with counselors through the group process. Particular attention was paid to the language and meaning associated with the construct.

Role of Researcher

Given the nature of the study, the researcher functioned as the primary instrument in data collection. As a result of this role, it was significant that the researcher was able to acknowledge assumptions, biases, and perspectives related to the construct of interest, as these are inevitable aspects of conducting qualitative research, described as “garments that cannot be removed” (Peshkin, 1988, p. 17). The researcher was a thirty-four-year-old female with thirteen years of experience working with adolescents with sexual behavior problems and nine years of experience as a counselor in various settings with

adolescents. As a community counselor specializing in addressing sexual behavior problems and trauma responses in adolescents and a doctoral candidate invested in education and research in sexuality counseling, the researcher was attached to the value of incorporating sexuality in the counseling process.

The researcher held a basic assumption that sexuality is an essential aspect of human development that is relevant to the counseling process for all age levels. Being a construct that has been poorly defined within the counseling profession, the researcher anticipates there would be a lack of consensus about how and when to address sexual concerns between professional counselors. The researcher also held the assumption, consistent with social constructivist philosophy, that knowledge is created within discourse communities, where it is negotiated between the individual and the particular environment. The agreed-upon language expresses the outcome of the negotiation process and is accepted as the definition and meaning associated with the construct.

Because it is impossible to extract subjectivity from the research experience, it is important for researchers to monitor their own subjectivity throughout the research process to identify where the research may have been impacted, whether positively or negatively (Milner, 2007; Peshkin, 1988). According to Peshkin (1988), not monitoring one's subjectivity leads to an "insinuation" of "personal stakes" in the research, regardless of attempts to maintain objectivity. The following is some of the "subjective Is" anticipated to impact the current study regarding sexuality with counselors.

- *Advocate I:* This aspect of the researcher speaks out about how avoidance of sexual education and discussion in spite of a flooding of sexual stimuli in American society leads to the perpetuation of sexual abuse; may have come into

play during interviews where the researcher may have sought opportunities to advocate on behalf of the past, current, or future clients of the counselors in the study.

- *Counselor Educator & Supervisor I*: This aspect of the researcher seeks to train and educate counselors about incorporating sexuality interventions into practice; may present when the researcher perceived a lack of awareness of particular skills or knowledge that she viewed as necessary for sexuality intervention.
- *Counselor I*: This aspect of the researcher seeks to discuss what intrapsychic barriers exist to providing sexuality interventions with their clients; may have presented when she perceived that a counselor has a personal issue preventing him/her from addressing sexuality in counseling.
- *Doctoral Student I*: This aspect of the researcher is motivated to “get done;” may present when she became frustrated at the length of the process.
- *Judgmental I*: This aspect of the researcher is critical of other counselors in the manner in which they address/don’t address sexuality with clients; may have presented when she perceived that the interventions—or lack of—contribute to maintaining sexual dysfunction rather than promoting sexual wellness.
- *Sexuality Wellness I*: This aspect of the researcher that promotes a perspective of sexuality as part of overall wellness rather than highlighting dysfunction; may have presented itself if counselors being interviewed promote a lens of sexual dysfunction rather than wellness.

Following recognizing the researcher’s subjectivity, it was necessary to take field notes and reflect upon reactions to the data consistently throughout the study. These

forms of documentation were conducted during and after the researcher logs onto the online site and included both ideas, questions for further exploration, and reactions to the data itself. In addition to ongoing field notes and journaling, the researcher also enlisted assistance in coding the data by two other persons with training and experience in qualitative analysis. Triangulation and member checking was also utilized to make sure that the data was transcribed correctly and that the participants had an opportunity to clarify any unclear responses during the discussion.

Data Analysis

Given that the focus group and individual interviews were conducted in an online format, information was copied into a word document on the same day of facilitation. Data also included follow up questions by the researcher and/or other participants throughout the discussion. Because transcription was not necessary, the researcher then enlisted the assistance of two additional qualitative researchers in the coding process. The coding process followed the interpretative phenomenological analysis (IPA) approach, a well-established technique for data analysis that has been both used in individual interviews and modified and implemented in the analysis of focus group data and captures the experiential components that other forms of analysis often miss in analyzing focus group data. The IPA method as it applies to focus groups is recommended to consist of eight distinct steps of analysis. (Palmer et al., 2010). For this study, the phenomenon was observed in individual participants both in the individual interview and the focus group formats.

After reflecting on researchers' preconceptions of the construct under investigation, the researchers followed six steps of analysis, with steps one through four

focusing on each participant. The first step involved reading through the transcript without making notations. The second step involved identifying what the participants identify as important, with particular attention focused on the language and meaning used in the discussion/interview related to sexuality. In the third step, emergent themes began to be identified. In the fourth step, the researchers examined connections across themes. The fifth step of analysis involves repeating the analysis with the next case. Finally, the sixth step involves identifying patterns across participants regarding sexuality (Smith, Flowers, & Larkin, 2012). In addition to being able to add follow-up questions, participants will have the opportunity to reviewing the researchers' preliminary analysis via email.

Trustworthiness

To ensure the trustworthiness of the study, several strategies were implemented. In accordance with IPA previously outlined, bracketing was utilized by the researcher through journaling and taking field notes conducted throughout the duration of the study, to include during the participant selection and coding stages and served to monitor the researcher's own bias, assumptions, and meanings associated with the construct of interest and the data (Palmer et al., 2010; Smith, Flowers, & Larkin, 2012). Engaging in bracketing allows the researcher to increase self-awareness not only of stance at the onset of the study but also to shifting perspectives over the course of the project as well as new information and perspectives are encountered (Fisher, 2009).

In addition to bracketing, member checking was conducted, in which the participants were provided with a draft of the final report to ensure accurate representation of their ideas. Participants were offered the opportunity to clarify or amend

any responses that were included in the final report. The inclusion of participants in the final review incorporated accountability to the representation of the data generated by the study.

Finally, triangulation provided additional trustworthiness to the current study by using multiple perspectives in aspects of the study. Several types of triangulation were implemented, including data triangulation, investigator triangulation, and methodological triangulation. Data triangulation involves using different sources of information. In the current study, data was acquired from counselors in different concentrations of training-school and clinical mental health/community, with each concentration providing sexuality interventions in different settings. Counselor educators offered an additional perspective due to their knowledge of and involvement in the training of counselors. Investigator triangulation involved using several different investigators in the analysis of the data and execution of the study. In the current study, two additional researchers assisted in conducting analyses of the data. Congruencies in interpretation were indicators of increased validity. Methodological triangulation, involving multiple methods, was included in the current study by incorporating opportunities for individual feedback during the study through an option to correspond privately with the facilitator and an invitation at the conclusion of the study and participation in the focus group discussions.

Conclusion

Chapter Three included the research questions and methodology proposed to answer the questions. The research questions, participants, procedures, data collection, ethical measures, instrumentation, and data analysis have been detailed. The research methodology included the implementation of a phenomenological, qualitative design,

using a synchronous online focus group and two individual interviews, counselors from various concentrations and levels of experience. The focus group was facilitated through the conferencing and networking site 24im over a two hour time period, with the researcher extracting participant responses from the site and transcribing them into a word document, which was then stored in a secure online storage service. Data was analyzed using the IPA method. Chapter Four will include a discussion of the results from the phenomenological study. Chapter 5 will include the implications of the results reported in Chapter 4.

CHAPTER IV

RESULTS

The primary purpose of this study was to investigate counselors' perception of sexuality and sexuality counseling. In this chapter, the results of one focus group and two individual interviews are presented through themes. The four themes detailed are sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training is insufficient.. Within the last two themes, sub-themes are discussed in detail. As themes are described, quotes are provided to support each theme. Participants are identified using a pseudonym.

Description of Participants

E-mail invitations were sent to licensed professional counselors throughout the United States, first using the Psychology Today database, followed by emails to professionals in North and South Carolina. The researcher utilized contact information for known professionals with a request to forward the information to colleagues known to them. There were a total of six participants who met the criteria and were able to participate in the study. Specific criteria shared by participants included being professionally licensed and reporting to have addressed sexuality with more than one client. Demographics were collected relating to participants ethnicity, gender, age, highest degree earned, and work setting (see Table 1). Of the six participants, one was a school counselor and five were mental health counselors. All of the participants were Caucasian. Five participants were female, and one was male. Two participants were

between 30-39 years of age; one was between 40-49 years; one was between 50-59 years, and two were over 60 years of age. Most participants resided in North or South Carolina, and one resided in Iowa. Their work settings varied among participants. Three participants worked in a private practice; one worked in a day treatment program, and the remaining two participants worked in a clinical program within a school setting. Years of post-licensure experience varied among participants, with three reporting less than five years; one reporting 5-10 years; one reporting 10-15 years; and one reporting over 15 years of experience. Three of the six participants reported feeling “very comfortable” with addressing sexuality; one reported feeling “moderately comfortable;” one reported feeling “fairly comfortable;” and one reported feeling “not comfortable.”

Table 1. Survey Responses of Study Participants

Demographics	“Susan”	“Ann”	“John”	“Mary”	“Jane”	“Jennifer”
<i>Race/Ethnicity</i>	White	White	White	White	White	White
<i>Age Range</i>	50-59	30-39	60+	60+	40-49	30-39
<i>Gender</i>	Female	Female	Male	Female	Female	Female
<i>State</i>	Iowa	SC	NC	SC	NC	NC
<i>Highest Degree</i>	Masters	EdS	D.Min	Ph.D.	Masters	Masters
<i>Years of Experience</i>	5-10	<5	15+	10-15	<5	<5
<i>Concentration Area</i>	Clinical Mental Health	School	Clinical Mental Health/Pastoral Care	Counselor Education and Supervision	Clinical Mental Health	Clinical Mental Health
<i>Work Setting</i>	Private Practice	School/Clinical	Private Practice	Private Practice	Day Treatment	School
<i>Sexuality Training</i>	Workshop Self-education	Course, workshop, supervision	Course, workshop	Workshop, supervision	Supervision, self-education	Course, self-education
<i>Level of comfort addressing sexuality</i>	Not comfortable	Very comfortable	Very comfortable	Moderately comfortable	Fairly comfortable	Very comfortable

Analyses of Research Findings

This study sought to investigate the construct “sexuality” and “sexuality counseling” from the perspective of counselors. One online focus group and two individual interviews were transcribed and analyzed. The findings from the analyses suggest four overall themes were present in counselors’ perceptions of their experiences: sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training is insufficient. Within the last two themes, sub-themes were noted. Counselor perception of sexuality included patterns related to language, meaning, and influences upon counselors’ conceptualization of sexuality. Three dialectical patterns were noted in the theme of dialectics of sexuality counseling, including wellness/dysfunction, subjectivity/objectivity, and flexibility/structure. The insufficiency of sexuality counseling training included a diminished impact of counselors’ sexuality training and thoughts on sexuality training in Counselor preparation. Analyses of the transcripts from the focus group and two individual interviews supported the themes that were developed.

In examining the construct “sexuality,” it was intended to examine both the language and meaning conveyed by the participants. Through the course of the study, it was evident that, although related, language and meaning were distinct in the current study. The participants did not present a common language regarding sexuality in the current study. Consistent with constructivist philosophy, each participant had his or her own language to express concepts. The language used to express ideas regarding

sexuality served to frame the meaning that the participants attributed to sexuality, which was consistent across participants and organized into specific themes. Therefore, multiple words could communicate the same conceptualization of sexuality.

Participants discussed their perceptions of sexuality. The conversations were initiated when counselors were asked about their definition of sexuality and influences of their perception of sexuality. Counselors demonstrated a perception of sexuality that appeared to be based on a wellness-oriented lens. Using language as a gauge for participants' meaning attributed to sexuality, it appeared that they organized their conceptualization along two patterns: the multi-dimensional and developmental nature of sexuality.

Sexuality is Multi-dimensional

The first theme noted by participants in this study regards the multi-dimensional nature of sexuality. The manner in which participants viewed sexuality is best described as “multi-dimensional” due to the various elements that were included in the description of sexuality. In particular, participants agreed that there were different distinct elements of sexuality that were inclusive within the construct, with some elements falling within those elements. Hence, the depth and complexity of the construct warrants recognition as being labeled as such. Counselors unanimously indicated personal definitions of sexuality that focused on healthy, developmental aspects of the construct, using expressions such as the ability to “interact on a physical, emotional, and spiritual level to procreate, connect or have deeper experiences of play” (Jane) or “an attraction to another person through sensation or responses, a desire or interest in others” (Susan). It was apparent that participants viewed sexuality as a positive aspect of human development

and experience. Participants provided more details to their conceptualizations over the course of the interview or focus group session as other questions were introduced. While clarification took place in individual interviews regarding counselors' definition of sexuality, negotiations regarding the language selected in participants' definition were particularly noted in the focus group, where the conceptualization of sexuality appeared to expand from original responses, seen in the following excerpt:

John: Concur that it involves physical, emotional and spiritual aspects (plus more) but should also be more than attraction or connection. There should be some aspect of sensual or erotic to be regarded as sexuality.

Jane: And what Susan added of course can lead to social realms too

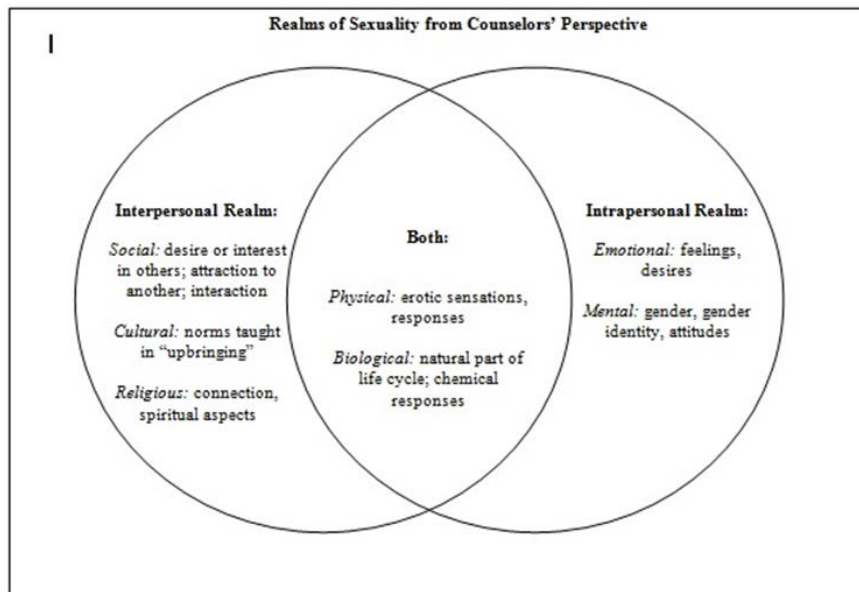
Jane: I guess in response to John, yes, good point. It has a more specific physical reaction and oxytocin etc than any physical play

Susan: sexuality does not have to be just a connection with someone else. It can be explored through our own connection with self through masturbation

The multi-dimensional nature of the meaning of sexuality that the counselors in this study noted can be placed along a dialectical continuum, with aspects falling within interpersonal and intrapersonal realms. In addition, some aspects of sexuality could be found to a degree in both realms (see figure 4.1). The interpersonal realm included such aspects as social, cultural, and religious experiences related to sexuality. One counselor highlighted that sexuality involves “an attraction to another person through sensation or responses, a desire or interest in others” (Susan), and another counselor stated that sexuality is “the part of ourselves that can interact on a physical, emotional and spiritual level to procreate, connect or have deeper experiences of play” (Jane). In contrast, the

intrapersonal realm included the emotional and mental aspects of sexuality. One counselor stated that sexuality is “all your feelings, attitudes, desires and experiences towards sex” (Jennifer) and another stated that “it also can include gender, gender identity, sexual orientation, in addition to the emotional and spiritual” (Susan). Aspects of sexuality noted by participants that involved both the intrapersonal and interpersonal realms included physical and biological experiences of sexuality, as noted by one participant who stated that “it is biological and a natural part of our life cycle” (Susan) and another participant who emphasized “the capacity for an individual to have sensual and/or erotic sensations, experiences and responses” (John). Through the focus group and interview process, the complexity of sexuality became more evident as participants verbalized their perspectives and attempted to integrate both the responses of others and their responses to subsequent questions into their conceptualization of sexuality. Counselors relied heavily on a holistic perspective to conceptualize the construct and demonstrated an openness to exchanging ideas with each other and clarifying their own responses when group members or the researcher requested, reflected inaccurately, or challenged their responses.

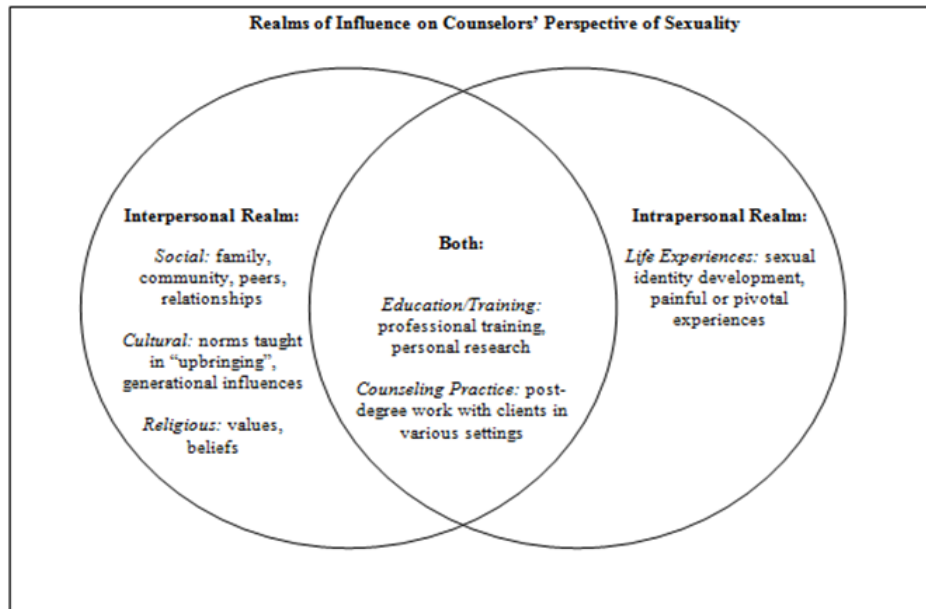
Figure 4.1. Realms of Sexuality from Counselors' Perspective



Participants continued the theme of emphasizing the multi-dimensional when asked about factors that influenced their perspective of sexuality. Influences, like aspects of sexuality, could be categorized in interpersonal and intrapersonal realms, with some influences falling in both (see figure 4.2). The interpersonal realm of influences involved both social factors—such as family, community, and relationships—and cultural factors—such as religion—what two participants labeled “upbringing,” and generational aspects. One counselor stated “I grew up in the 50's and early 60's when it was expected that good girls would be virgins until marriage and not talk about sex - my mother gave me a book to read about puberty - I didn't ask any questions!” (Mary). Another counselor stated that her influences included “first the Catholic church. Then definitely my social environment. Then my relationships” (Jane), and a third counselor emphasized the importance of “my family and community” (John). The intrapersonal influences on counselors’ perception of sexuality included life experiences, which may have included identity development, as well as pivotal or painful experiences. One counselor

highlighted that “being sexually molested as a child and not being protected by my parents, the people I knew in college helped and working with a therapist to deal with all of it helped greatly” (Susan). Another counselor emphasized the importance of exposure in the process of her own sexual identity development when she stated “although I am not homosexual, I’ve been to many clubs/bars with others who are and been privy to their world from friends’ first hand experiences” (Jennifer). Influences that involved both interpersonal and intrapersonal realms included professional training and clinical experience, which was viewed as less influential than the other two realms by participants. Mary stated “Of course, education was a major influence. - as I entered the helping fields I quickly learned that sexual energy was part of everything.” John mirrored the impact of clinical experience when he said, “After graduation and when the clinicians start practice is when we realize we are not well equipped for much of what comes into the office.” Even when participants expressed factors in the intrapersonal realm, the significance and resolution of these experiences appeared to be significantly influenced by factors in the interpersonal realm, demonstrating that even private experiences of sexuality are impacted and influenced by interactions with others, whether harmful or healing.

Figure 4.2. Realms of Influence on Counselors' Perspective of Sexuality



Sexuality is Developmental

The second theme regarded sexuality as a developmental process, due to the changes that occur in one's sexuality over time: sometimes as a result of the stage of life; sometimes due to social and community influences; and sometimes as a result of significant events or experiences. Even within the discussion itself, the participants' conceptualization of sexuality experienced changes. In the focus group setting, participants were able to note the patterns in the development of the discussion and highlight areas where further exploration was warranted. One member of the focus group (John) appeared to note the contrast between counselors' perception of sexuality and clinical examples presented in the discussion when he commented that the group had "moved quickly from sexuality to difficult cases involving abuse, incest and shame." Following his observation, the group wrapped up their discussion of difficult cases and moved to the next question in the discussion. Language negotiations were not limited to the focus group format, but in the individual interview, the negotiation of language

involved more direct involvement of the researcher, such as when Mary responded to the question about the influences on her perception of sexuality. Her response was followed by an additional question to illicit a more detailed explanation of a particular phrase:

Mary: "My upbringing was fairly traditional Southern - I didn't have any traumatic sexual experiences as a child or adolescent

Researcher: Could you expand on "fairly traditional Southern" and what that means related to sexuality?

Mary: pretty interesting term, isn't it? I guess I mean that...."

Mary continued by expanding upon the phrase to provide more details regarding social changes in her generation that impacted her perception.

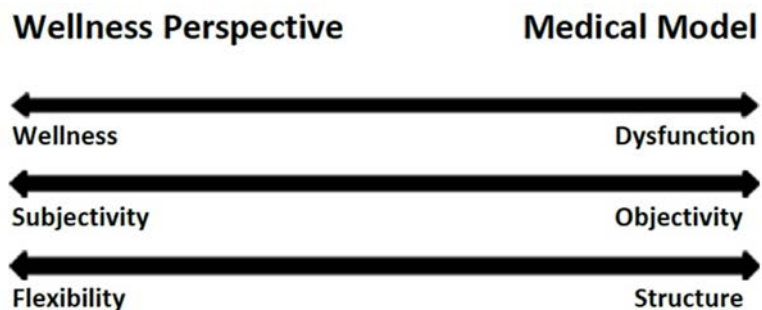
Over half of the participants either directly stated or implied that sexuality is developmental. Participants who emphasized that sexuality is present across the lifespan stated that in addition to being a "natural part of our life cycle" (Susan), it is "a positive part of our development as full humans" (Jane). While discussing counseling interventions, participants emphasized the ongoing nature of sexuality further by sharing the experience of not being "surprised when issues related to sexuality emerge because at the end of the day sex is part of most life experiences" (Mary), and "I also feel sexuality...continues throughout your life so this helps to work with parents and children" (Ann). Influences on counselors' perception of sexuality were also viewed as developmental in nature by participants. Counselors in this study valued the continuing nature of changes regarding their views on sexuality as they encounter new people and experiences in both personal and professional contexts. One counselor stated that he is "still having my perspective influenced" (John), and another counselor mirrored this

opinion when she added “I think we are constantly learning and having our perspective on sexuality influenced” (Jennifer). Mary specifically connected her perspective to her clinical experience when she said “My perspective continues to change as I become more invested as a therapist.”

Sexuality Counseling is Dialectical

Participants discussed their experiences providing sexuality counseling. The conversations were initiated when counselors were asked to share a recent example from their own practice and asked how their definition of sexuality impacted their work with clients. Counselors demonstrated dialectical tensions encountered when providing interventions regarding sexuality that were not as apparent when they discussed their conceptualization of the construct. It appears that the application of their view of sexuality in counseling was a struggle for these counselors. The dialectical tensions fell within three distinct patterns, including balancing a personal definition of sexuality based on wellness with addressing dysfunctional sexual behaviors in clients; honoring their subjective experiences regarding sexuality while remaining objective as a practitioner; and balancing flexibility with providing structure for clients (see Figure 4.3).

Figure 4.3 Dialectics in Sexuality Counseling Practice



Wellness and dysfunction. The wellness-dysfunction dialectic became apparent when participants shared case examples from their clinical practice. In spite of defining

sexuality in developmental, wellness-based terms, most clinical examples highlighted dysfunctional sexual behaviors that served as the focus of treatment. One counselor shared

I have a client who is a sex addict and talking about healthy sexuality and what that means within his relationship. How to express sexuality without getting triggered into his addiction and the ability to explore in a healthy way (Susan).

Jennifer presented the case of an

11 year old male client, who had been sexually abused from age of 4-5 by multiple individuals. He is trying hard to form attachments to females in his life, and is starting to hit puberty and considers himself a 'monster' based on past abuse.

Another manner in which this dialectic presented involved the importance of addressing sexuality within the context of other life dimensions, regardless of the presenting issue in counseling. Mary stated of her experience,

The most recent was with a female, in her late 40's, in a relationship with a man who has ED due to a serious medical (degenerative) issue. The woman does not care that he can't have an erection but he feels like he has lost his manhood and is hesitant to even try.

Ann focused on systemic and developmental aspects with

two sisters who are struggling with their sexual identity. One identifies as gay the other not sure maybe bi. We discussed what each one of these ids meant to them....also explored mothers sexual identity and what it meant to her for her daughters to id with something else.

It appeared that the application of counselors' conceptualization of sexuality as a healthy aspect of development becomes complicated when working with clients when other factors, such as relationships, dysfunction, abuse, and shame present themselves.

Subjectivity and objectivity. In providing sexuality counseling, participants also expressed struggles with balancing subjectivity, which afforded the greatest influence on their perception of sexuality, with maintaining objectivity as a clinician. One manner this struggle presented involved counselors seeking to teach clients about healthy sexuality while keeping their personal definition out of the sessions. John shared "I do not see it as much about my definition of sexuality as much as my support of what is healthy and appropriate for the clients in their life and relationships," and Susan stated "I let my clients define sexuality and use their definition. I will also help them explore what sexuality can include. I try to keep my definition out of the process." Another way that participants expressed this dialectical tension was balancing self-awareness with focusing on the client. Jane shared strong emotions regarding the perception of one client's family members regarding the client's sexuality when she stated

Of course incest seems to be on God's ok list!!! :(.... sorry. I get bitter about our clients' families sometimes. Just saying that that (sexual abuse) was a part of her history, and it is specifically the fact that the letter was to a female that is upsetting to them.

Another participant expressed similar difficulties when she shared

I tried, of course, to remain detached from that but honestly found them fascinating. I am ok with polyamorous and kinky choices and found it interesting how they used scripture to defend it all. Not an argument you hear often.

Sometimes it was hard not to ask a bunch of questions and stay focused on the identified problem (Jane).

Yet another counselor in the study identified that her struggle was specific to a particular sexual issue. Susan shared that “the only client that I have difficulty with was a perpetrator. I enjoy the exploration of sexuality with other clients. Finding out their definitions, morals, beliefs and try to keep my beliefs out of the counseling arena.” In response to Susan’s disclosure about difficulty remaining objective with perpetrators, John responded “Susan, that is why I recuse myself from working with perps. The same with domestic violence perps. I struggle with objectivity in those areas.” The final manner in which the subjectivity-objectivity dialectic presented itself with participants involved balancing being authentic with maintaining professional boundaries with clients. Jane shared “I definitely walk a line though since I am school based and working with minors from very conservative rural families.” For Mary, it appeared that anxiety regarding this dialectic was minimal. She shared “Based on my definition sexuality is not usually a separate issue but is integrated into many life issues.” Thus, although the struggle with balancing subjective experiences with maintaining objectivity presented in various ways, all participants expressed having some degree of difficulty at some point in their professional development.

Flexibility and structure. The final dialectic observed in participants’ clinical experience involved balancing flexibility with providing structure in the counseling process regarding sexual concerns. Specifically, participants emphasized valuing the clients’ perception while also providing guidance regarding healthy sexuality. One counselor stated that her flexibility allowed her to provide structure for clients when she

shared “I feel being open and fluid in the definition as it means different things to clients helps me focus on what is impacting them and what they are wanting to work on or change” (Jennifer). Participants noted a difference in the degree of flexibility and structure based upon the developmental stage of the client. John stated “With adolescents, the more concrete, the better. They struggle with abstract concepts and relationships. However, sexuality and relationships are very abstract and fluid. That causes problems in treatment and understanding.”

Sexuality Training in Counseling is Insufficient

Participants discussed their perception of sexuality counseling training. Perceptions were shared when counselors were asked about their perceptions of sexuality before and after becoming a counselor and their thoughts on sexuality training. Half of the participants indicated taking a graduate course in sexuality, and half indicated that their knowledge was acquired through independent, informal research. Half of the participants reported addressing sexuality in supervision, and over half had attended a workshop or presentation. Overall, participants in this study all indicated some form of external guidance in the area of sexuality. Therefore, reflections on their training provided insight regarding the quality of training in sexuality and sexuality counseling being provided in the profession. Two themes were noted in counselors’ responses, including the insufficient impact of their training in sexuality and the need for further training in this area.

Insufficient training. Regarding their own sexuality training, participants reported degrees of an insufficient impact of training in sexuality counseling to prepare them for practice in this area. The perception that training had no impact was indicated by

some of the participants. Jennifer stated “I’ve always been open to learning more before and after becoming a Counselor so nothing has changed for me in my perspective.”

Minimal change was indicated by Susan, who shared “I believe I have open and broadened my views of sexuality in some ways, I have always been very accepting of sexuality. However, being a counselor has taught me a few things that I did not know is some areas of sexuality.” As previously stated, participants viewed that counseling practice had more of an impact than their training in sexuality counseling. Mary shared with the researcher “as I entered the helping fields I quickly learned that sexual energy was part of everything.... After I entered the counseling field I discovered that sexual problems/issues were usually part of other aspects of life and could not usually be dealt with independently or compartmentalized.” Ann expressed her perspective, “I think I have always been open to sexuality not frightened by it but I think the difference is now I truly see how much it impacts a person’s life.”

Need for more sexuality training. Given the view that their sexuality training had little impact on their perspective of sexuality, it is not surprising that participants also emphasized the need for further training in the counseling field. John stated “There is not enough training in our graduate programs. Difficult to include since that is not a requirement for licensure or graduation.” In addition to expressing the need for increased training, counselors expanded to emphasize the importance of integrating that training across master’s preparation. Mary shared

I think sexuality counseling/training needs to be integrated into all counselor ed courses, just like we do with diversity issues - counseling students must be clear about their own sexuality issues in order to maintain healthy boundaries with those

who may be struggling in this area - and of course we need much more research in this area!

Ann mirrored this opinion when she said

All clients in clinical school settings—whatever the setting is—have a need to learn speak about and grow from discussion about sexuality. This change needs to begin in the training programs for counselor. Help them to embrace and have the skills set to go out in their profession and work with sexuality issues, normative or abnormative.

The importance of positive role modeling and mentoring was also mentioned through discussion of examples of poor leadership in the profession regarding sexuality. Jennifer shared “In my graduate program we had one class that was taught by someone that opened the first class by saying “I am not comfortable with teaching this but had no choice.” John shared a similar experience in his graduate course when he responded “In my graduate course, the instructor admitted that he was teaching it to help determine why his wife left him for a woman and if we could help him figure it out.” In an individual interview, Ann shared the possible impact of generational influences on the value of sexuality training when she stated “Counselors that have been the grandfathers and grandmothers of this profession most likely did not have parent who spoke a lot about sexuality to them.”

Summary

In this chapter, the results of the focus groups were presented in four themes: sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training in counseling is insufficient. Supporting quotes were

provided to detail and explain the themes. The sub-themes within two themes were also discussed. A discussion of these themes as well as the implications for the counseling profession are presented in Chapter Five.

CHAPTER V

DISCUSSION

The current study examined the perceptions of counselors regarding the constructs “sexuality” and “sexuality counseling.” In this chapter, the study is summarized, limitations are identified, and themes are discussed. Implications for counselor educators, counselors, supervisors, and counseling research are also explored.

Overview

The purpose of this study was to gain a greater understanding of practicing counselors’ conceptualization of sexuality and experience providing sexuality counseling interventions. Also of interest was the perspective of counselors regarding sexuality counseling training. To access this information, data was collected through the use of an online focus group and two online individual interviews. Six counselors participated in the study. The focus group and interviews were transcribed and then coded by three different researchers.

The results showed that counselors address sexuality in various settings with clients. The data from the focus group and two individual interviews yielded four themes. The themes that presented include: sexuality is multi-dimensional; sexuality is developmental; sexuality counseling is dialectical; and sexuality training is insufficient. Subthemes included: three distinct dialectical tensions in providing sexuality counseling, the diminished impact of training, and the need for further sexuality training in

counseling. Participants' responses provided information about the sexuality counseling from counselors' perspectives.

Limitations of the Study

Limitations that presented themselves in the current study were addressed in several ways to minimize their impact on the results. Trustworthiness was increased by bracketing, member checking, and triangulation. Bracketing took place through researcher journaling and maintaining field notes throughout the study process to mitigate bias (Fisher, 2009). Member checking involved the inclusion of participant feedback both following transcription of the focus group and individual interviews and the completion of the final report, at which points participants were invited to make corrections, clarifications, or comments regarding the study (Glesne, 2011; Maxwell, 2005; Palmer et al., 2010). Triangulation included three types—data, investigator, and methodological. Data triangulation involved including counselors from various concentrations and work settings. Investigator triangulation involved using two additional researchers in data analysis. The involvement of two other experienced qualitative researchers in data coding increased the reliability of the themes. Each researcher coded the data independently, followed by collaboration with each other to identify themes. Methodological triangulation was accomplished by including opportunities for individual feedback and acquiring information via a focus group and individual interviews (Glesne, 2011; Maxwell, 2005; Palmer et al., 2010).

Because the primary data collection tool was the author, it is important to acknowledge researcher bias throughout data collection. As a counselor providing sexuality-specific interventions to clients for the past ten years, I had significant

professional investment in the research topic. Because of this experience, I reflected upon her own conceptualization of sexuality, the experience of providing sexuality counseling, and the relevance of sexuality training in the counseling profession. In addition, I had also provided training and education to other counselors as a guest lecturer, co-instructor, presenter, consultant, and supervisor. While developing the research questions, I reflected upon my own potential responses and looked forward to hearing the responses of other counselors.

Regarding participants who volunteered for the study, three were known to me professionally, and although they were unaware of the details of the study, they were, in general, familiar with my experience in the area of sexuality. One of the participants had provided supervision in the past for my own supervision licensure. Another participant was a former colleague seven years ago in a school-based setting. The third participant was a student in the same doctoral program as I. The potential impact of the familiarity with myself could have impacted the participants' responses in favor of the research questions, although contact with these persons was either non-existent during the time of research development or focused on topics other than the study. During the focus group and the interviews, I reflected upon my own work with clients and research in the area. Although I was mindful about providing responses that were reflective and asking for clarification of phrases even when I felt confident of their meaning, there was one occasion in which I highlighted the word "shame" in the discussion with the focus group. Intended to reflect the common emotion expression by several group members, in retrospect, I felt that a more open statement would have been more appropriate. The group continued to clarify their meaning in spite of the introduced word, and the two

other researchers expressed that the discussion was not negatively impacted in their opinion. At another point in the focus group discussion, the participants began discussing difficulties working with sexual perpetrators. Although I refrained from comment, I noted a strong desire to participate in the discussion further. Having training as a counselor educator, I also felt compelled at times to provide education and training to the participants, as anticipated prior to the study. Overall, I resonated with the more experienced counselors in the group, who expressed more integration of sexuality into their counseling practice than those with less experience.

I enjoyed hearing the perspectives of counselors from such varying years of experience and training regarding their understanding of sexuality and experience providing sexuality counseling. It was validating to hear them discuss their struggles in their efforts to help clients, as well as reassuring that the participants viewed sexuality as a normal part of development. It was also disturbing to hear that participants felt that there is a lack of mentorship in this area.

I wondered, on numerous occasions, about how the method impacted the information received. I believed that having more people involved in the focus group may have generated a more in depth discussion or that individual interviews may have generated more disclosure regarding the subjective experience of discussing sexuality with clients. It seemed that some participants in the focus group may have censored their responses due to social pressure. My strong effort to not interject my own conceptualizations led to a more distant communication style than is typical. This difference may have also inhibited participants' responses.

There were other limitations to the current study. In spite of efforts to recruit participants of various ethnicities, genders, sexual orientations, and regions of the country, response was extremely minimal to these attempts. In comparison to the number of invitations submitted, very few responded, with most of those responding indicating that they were not interested in participation. Several potential reasons for lack of participation could be suggested, such as discomfort with the topic or the format of the study. However, it would be impossible to verify any of the potential reasons. It is possible, in contrast, that the counselors who chose to participate in the study did so out of a particular interest or investment in the topic. Therefore, the study did not include a diverse range of participants representative to the actual demographics in the counseling profession. Participants were white, predominantly female, and mostly from the Southern region, presenting limitation also with regards to culture. Because sampling was purposeful rather than random, the participants spoke about their own experiences rather than about the perspectives of the counseling profession. Given the demographics of the participants and the sampling method, the results of the study may not be generalized.

In addition, although online focus groups tend to warrant a decreased likelihood of self-censoring, there still may be a possibility that participants withheld their opinions and experiences due to the dynamics of the discourse community. In particular, once a participant expressed a strong opinion regarding sexuality or sexuality counseling, members of the discussion may not have felt comfortable challenging that opinion. The online format may have contributed to this dynamic rather than ameliorating these concerns due to the lack of non-verbal communication that a traditional focus group would have provided.

Discussion of Themes

Although periods of focus on sexuality have been presented in research, the focus has remained on the importance of training in sexuality counseling. Little has been presented about how counselors and counselor educators conceptualize sexuality and sexuality counseling and incorporate it into practice (Hays, 2008; Parritt & O'Callaghan, 2000). In this section, each of the four themes will be discussed, highlighting consistency and inconsistency with the literature.

Consistent with the constructivist perspective, the vehicle for determining how counselors' perceive a construct is the language used to express that construct. In essence, language is meaning, becoming viewed as truth when agreed upon among a group of people (Prawat, 1996; Prawat & Floden, 1994). Thus, the language used by professionals, both influenced by and an indicator of attitudes about sexuality can be examined to determine the meaning attributed to sexuality (Beasley, 2008; Lazarus, 2008; Paiva, 2005; Prawat, 1996; Tiefer, 2010; Wampold, Ahn, & Coleman., 2001). Although the literature indicates that the medical model language has been incorporated into Counselor Education programs (Murray, 2006; Smith & Robinson, 1995; Urofsky & Engels, 2003) and many sexuality education programs in the community have relied upon a medical conceptualization to educate about sexuality (Giami & Pacey, 2006; Zwibelman & Hinrichsen, 1977), counselors in the current study indicated two themes in their conceptualization of sexuality that reflect a wellness perspective: an emphasis on sexuality as multi-dimensional and viewing sexuality as a developmental, rather than

mechanical, process. The individual nature of the participants' language used to express the meaning of sexuality supports the argument presented in constructivist philosophy that meaning is created.

Sexuality is Multi-dimensional

The literature has indicated that there is little clarity and agreement regarding a concrete definition of sexuality (Jackson, 2010; Tiefer, 2006). Historically sexuality has been viewed in terms of physiological function and dysfunction (Beasley, 2008; Bradley & Fine, 2009; Bullough, 1975; Murray, 2006). However, recent emerging consensus across disciplines that sexuality is more complex than mere biological function (Bogey, 2008; Fyfe, 1980; Gill & Hough, 2007; Jackson, 2010; Lazarus, 2008; World Health Organization, 2012), with new conceptualizations of sexuality including both the physiology of and the meanings associated with sexual behavior (Bogey, 2008; Lazarus, 2008; World Health Organization, 2012). An example of the shift in conceptualization includes the New View of Women's Sexual Problems, which takes into account biopsychosocial influences on sexuality (Southern & Cade, 2011; Tiefer, 2006). Participants in the current study mirrored the trend toward viewing sexuality as more complex and holistic than prior, more biologically based, perspectives. Specifically, participants indicated various aspects of sexuality within two overlapping realms: interpersonal and intrapersonal. The interpersonal realm is inclusive of the sociological perspective in the literature, which views sex is a social behavior, with norms being defined within a social and cultural context (Diamond & Hubener, 2012; Lazarus, 2008;

Paiva, 2005; Southern & Cade, 2012; Trimble, 2009). The intrapersonal realm encompasses the internal experiences of sexuality, which includes the emotional and mental aspects. This realm respects the meaning that each individual creates regarding their sexual experiences (Southern & Cade, 2011). Because sexuality is considered a “health behavior with wide-ranging implications for mental and physical well-being” (Diamond & Hubener, 2010, p. 57), aspects of sexuality that were identified by participants, such as physical and biological experiences, would fall within both interpersonal and intrapersonal realms. Also consistent with recent literature, participants in the current study noted both the impact of sexuality on overall wellness (Beasley, 2008; Paiva, 2005) and its overall complexity (Trimble, 2009).

In spite of participants in this study viewing sexuality as complex and multi-dimensional in itself, wellness models in Counseling have not identified sexuality as its own dimension (Myers & Sweeney, 2005, 2008). Instead, sexuality has been implied within the contexts of other realms, without honoring the role that the participants in the current study indicate sexuality plays in overall well-being (Myers & Sweeney, 2005, 2008; Roscoe, 2009). In addition, participants in this study demonstrated acknowledgement of sexuality and sexual wellness within individuals rather than isolating conceptualization to a couple experience (Southern & Cade, 2011).

In opposition to the medicalized lens of sexuality, several authors in the field of counseling has emphasized the importance of social influences in sexual development, with sexual behavior learned through conditioning (Hogben & Byrne, 1998; Petersen &

Hyde, 2010; Sachs & Duffy, 1976) and sexual development influenced by parental behavior and interactions. The process of sexual behavior being impacted by social setting and cultural context has been labeled “sexual socialization” (Paiva, 2005, p. 346). Participants viewed the influences upon their own sexual development and conceptualization as multidimensional, including but not limited to social influences. Instead, the influences also included overlapping realms—interpersonal and intrapersonal—that included various aspects, mirroring their conceptualization of sexuality. The interpersonal realm included the social and cultural influences indicated in the literature. The intrapersonal realm included life experiences, such as gender identity, sexual orientation, as well as pivotal or painful experiences, such as sexual abuse. While participants noted that the intrapersonal realm was significantly influenced by the interpersonal realm, they still acknowledged the internal experience as distinct. Participants also indicated that influences that fell within both interpersonal and intrapersonal realms, professional training and counseling practice, had less of an impact on their sexuality development than the other two realms. Because meaning is re-negotiated in each discourse community in which an individual participates (Prawat, 1996; Prawat & Floden, 1994), the reduced impact of professional training on counselors’ perception of sexuality would indicate deficits in sexuality training.

Sexuality is Developmental

Recent literature in counseling has expressed the position that sexuality is developmental (Diamond & Huebner, 2012; Elders, 2010; Fyfe, 1980; Gill & Hough,

2007; Southern & Cade, 2011; Trimble, 2009), refuting the medical model's problem-center approach to addressing sexual concerns (Urofsky & Engels, 2003). Because of the increase in endorsement of a paradigm shift toward studying positive, normative, and pleasurable dimensions of sexuality and sexual functioning, sexual activity has come to be viewed as a health behavior connected to overall well-being (Diamond & Hubener, 2012). Participants in the current study concurred with this perspective, highlighting that sexuality is experienced across the lifespan and is a positive aspect of human development. They indicated personally experiencing sexual development being ongoing and appeared to attempt to integrate this perspective into their client conceptualization, lending itself to attempts to remain flexible in their clinical interventions. In spite of the emphasis in the literature on the heterosexual couple experience (Southern & Cade, 2011), participants included examples and experiences from their clinical experiences, ranging from childhood well into adulthood, with individuals and relationships. Participants also included experiences involving sexual minorities and alternative lifestyles as well.

Although the literature emphasized the developmental nature of sexuality (Diamond & Hubener, 2012; Elders, 2010; Fyfe, 1980; Gill & Hough, 2007; Southern & Cade, 2011; Trimble, 2008) and the influence of social and cultural contexts on sexuality development (Hogben & Byrne, 1998; Petersen & Hyde, 2010; Sachs & Duffy, 1976), there was an absence of acknowledgement in research that influences are also developmental. It would be reasonable to assume that if the meaning attributed to

constructs is impacted by each discourse community in which the individual participates (Prawat, 1996; Prawat & Floden, 1994), influences on sexuality development would also be fluid and ongoing. There was a consensus among participants in the current study that influences on their own sexuality development were ongoing as they encounter new people and experiences both personally and professionally.

Sexuality Counseling is Dialectical

According to the literature, there is confusion regarding whether sexuality counseling is a specialization (Gill & Hough, 2007; Nasserzadeh, 2009; Southern & Cade, 2011) or an essential skill (Bogey, 2008; Fyfe, 1980; Jackson, 2010; Parritt & O'Callaghan, 2000; Tiefer, 2006; Trimble, 2009; van der Kawaak, Ferris, van Kets, & Dieleman, 2010). Proponents of the latter emphasize a more holistic approach to sexuality counseling that includes addressing social, cultural, and political influences on sexual functioning (Tiefer, 2010). The contrast in messages creates a dialectical tension for counselors that leads to an increase in discomfort providing sexuality interventions (Bradley & Fine, 2009; Hays, 2008; Southern & Cade, 2011; Tiefer, 2006). While some counselors may avoid providing sexuality interventions (Hays, 2008; Parritt & O'Callaghan, 2000), the participants in the current study indicated efforts to assist their clients regardless of the degree of their discomfort. In addition, participants appeared to disagree with the assertion that sexuality counseling is a specialty and affirmed three specific dialectical tensions in their attempts to provide sexuality interventions: wellness/dysfunction, subjectivity/objectivity, and flexibility/structure.

Wellness and dysfunction. The dialectical tension between perceiving sexuality in terms of wellness or dysfunction dominates the literature, with most research on sexuality focused on dysfunction rather than health (Kleinplatz, et al., 2009; Lazarus, 2008). From the medical perspective, sexuality is a health concern, with an emphasis on alleviating disease, dysfunction, and disorder to regain a state of health and functioning (Bradley & Fine, 2009). Wellness models, emphasizing the healthy and developmental aspects of sexuality, have attempted to focus on sexual wellness while still maintaining loyalty to the medical model language and conceptualization of sexuality (Southern & Case, 2011; Bradley & Fine, 2009). Whereas sex therapy is designed to address sexual dysfunction and dissatisfaction, sexuality counseling has come to be defined as focused on sexual satisfaction and optimal sexual functioning (Southern & Cade, 2011). Implementation of a wellness-based sexuality counseling has proven difficult, with the normalization of sexual dysfunction both in sex therapy and in the media (Murray, 2006). Participants in the current study demonstrated this dialectic when they were asked to share examples from their clinical practice. Although participants conceptualized *sexuality* in terms of wellness-based terminology, their presentation of case examples included a struggle between the use of the medical model to conceptualize cases and how to work with perceived “dysfunction” from a wellness perspective. Participants did not discuss what interventions they utilized but rather expressed the sense of being stuck. When clients presented with sexual concerns that were viewed as developmental in nature, participants expressed less conflict. The disconnection between wellness

conceptualization and providing wellness-based interventions experienced by participants in the current study was mirrored in the literature. Counselors in one study were able to acknowledge that sexual symptoms were a common experience of female sexual abuse survivors but failed to include sexuality in the assessment or treatment process (Hodges & Myers, 2010).

Subjectivity and objectivity. Sexuality is recognized in the literature as a sensitive topic, with a tendency for counselors to avoid addressing with clients (Gill & Hough, 2007; Hays, 2008; Parritt & O'Callaghan, 2000). Historically, objectivity has been valued as a professional standard, derived from the medical model approach to resolving the identified “problem” (Wampold et al., 2001). Detachment is not possible in counseling due to the reliance on the relationship as a vehicle to facilitate change. Subjectivity is recognized to be present even in the diagnostic process (Dougherty, 2005; Zalaquett et al., 2008). As a result, the meaning and language counselors maintain regarding sexuality will impact clients (Urofsky & Engels, 2003). Postmodern sex therapy has developed to emphasize the meaning that people make of their sex lives and recognizes the subjectivity of assessing sexual problems in counseling (Gill & Hough, 2007; Southern & Cade, 2011). Consistent with the literature, participants in the current study acknowledged their own struggle with balancing professional objectivity with their subjective experiences, which were responsible for the greatest influence on their sexual development and conceptualization.

Most participants talked about efforts to separate their own definition of sexuality from their work with clients. Instead, participants emphasized relying on the clients' conceptualization and meaning regarding sexuality. This approach appeared to be effective, unless the client presented with dysfunctional sexual behaviors or conceptualizations. In these incidences, it appeared that counselors were less able to exclude their own conceptualization out of interventions. Therefore, although participants reported that they refrained from allowing their definitions to influence their work in an attempt to remain objective, the literature suggests that these efforts are ineffective due to the subjective nature of sexuality (Dougherty, 2005; Zalaquet et al., 2008). Some participants acknowledged difficulty remaining objective when confronted with specific issues, such as sexual perpetration. While participants perceived an ability to separate their own definition from the counseling process, they were more aware of the impact of strong emotional reactions within the counseling session, such as intense anger or curiosity. As recent literature suggests (Dupkoski, 2012), participants who were more aware of their subjective experiences reported to feel more effective in their interventions regarding sexuality.

Flexibility and structure. The recent paradigm shift in the literature toward conceptualizing sexuality in terms of wellness rather than dysfunction encourages greater flexibility in sexuality interventions (Fill & Hough, 2007; Tiefer, 2010). Both “sexual authenticity” and “sexual entitlement” are emphasized to empower clients to make their own decisions regarding sexual wellness (Tiefer, 2010, p. 371). In addition, discarding

the binary system in favor of recognizing that expressions of sexuality are various (Gill & Hough, 2007) means that counselors must balance providing structure in interventions with flexibility to meet the individual needs of each client. In the current study, participants recognized the need to balance these two skills based upon the developmental level and treatment goals of their clients. Although most of the participants emphasized flexibility over structure, several participants implied the ability to demonstrate both simultaneously, with one participant even stating that being flexible allowed her to provide structure within counseling process. In contrast to the wellness perspective in the literature, participants in this study emphasized the intention of providing structure regarding sexuality counseling to maintain professional boundaries. There appeared to be an understanding that clients would look to counselors for guidance, and they reported providing this guidance in the form of psychoeducational interventions.

Sexuality Training in Counseling is Insufficient

Training in sexuality counseling is not required for all counselors-in-training. Although some programs offer an elective course in the topic, CACREP standards only specify a required course in sexuality counseling for the marriage and family concentration (CACREP, 2009). Issues related to sexuality are addressed within the context of other topics covered in masters-level programs, including professional boundaries regarding sexual contact with clients in ethics courses; sexual minority issues in diversity-focused courses, and sexual disorders in assessment courses (Dupkoski, 2012). Participants in the current study identified the importance of sexuality counseling

training in their reflections from two perspectives: the insignificant impact of their own training and the need for further training in this area.

Insufficient Training. With sexuality counseling being perceived predominantly as a specialty (Gill & Hough, 2007; Nasserzadeh, 2009; Southern & Cade, 2011), it is not surprising that it is not viewed as a core competency in Counselor Education programs (CACREP, 2009). Viewing it as a special topic appears to be connected to decreased general training (Parritt & O’Callaghan, 2000; Southern & Cade, 2011). The professional standards most accepted for sexuality counseling are outlined by AASECT. However, AASECT does not require master’s level preparation for certification as a sex counselor, and masters prepared professionals are not eligible for certification as sex counselors. Instead, they are required to apply for certification as a sex therapist instead (AASECT, 2012). With such a gap in training, it is not surprising that participants in this study stated that their own professional training had little impact on their conceptualization of sexuality and sexuality counseling. Although all participants reported some degree of training in sexuality, only one participant indicated a significant change attributed to her training, and it should be noted that there were some generational influences co-occurring at the time of her training, such as the sexual revolution. The surge in investment in sexuality training was validated by the literature (Bullough, 1975; Fyfe 1980; Sachs & Duffy, 1976; Simon & Gagnon, 1984, 1986; Zwibelman & Hinrichsen, 1977). Rather, participants indicated that once they entered the profession, they became aware of their lack of preparation in the area of sexuality and began to

expand their awareness of the relevance of sexuality in counseling, regardless of the client population. Although the literature shows that variations in training and biases/beliefs can lead to variation in mental health services and a tendency to avoid sexuality with clients (Gill & Hough, 2007; Jackson, 2010), it was clear that the participants in this study were making attempts to address client concerns in spite of feeling ill-prepared to do so.

Need for additional sexuality training. The literature provides insight into training practices that have been effective and accepted in the helping profession. AASECT endorses the Sexual Attitude Restructuring (SAR) Model, originally developed by the Institute for Advanced Study of Human Sexuality in San Francisco, CA. This model involves systematic exposure to sexual material for the purpose of increasing awareness of one's sexual values and biases (Stayton, 1998). While CACREP does require human sexuality standards to be addressed in marriage, couples, and family programs, Counselor Education has largely neglected sexuality counseling training (CACREP, 2009). Participants in this study indicated a significant need for improvements in sexuality counseling training, with an emphasis that this training should take place in graduate level programs. In addition, participants expressed the perception that sexuality training should not be isolated to a course but integrated across courses, like multicultural training. Participants valued sexuality training regardless of the concentration or setting because they viewed sexuality as developmental and not isolated to couples counseling or the treatment of sexual dysfunction. Some participants

highlighted the significance of mentoring and role modeling in sexuality counseling, with two providing examples of poor leadership from counselor educators teaching the course.

Implications of the Study

The responses of the participants in the current study may not necessarily be generalized. However, their responses, in comparison to the literature on sexuality, provide an opportunity to further examine the role of sexuality in Counseling. With significant areas of consistency and inconsistency with information in the literature, the results of this study provide implications for counselors, counselor educators, supervisors, and future research in the field.

In the counseling process, recognizing that each person creates his or her own language and meaning regarding sexuality means that counselors need to be conscientious in clarifying and negotiating the language used by both the client and the counselor. Making efforts to ask clients specifically what they mean regarding certain terms and where they received their information regarding sexuality is important in helping to move clients toward healthy sexual expression. Specifically explaining what the counselor means when using certain terms will minimize confusion and assist in addressing clients' concerns. In addition, it is important that counselors are clear with clients where their information is coming from regarding sexuality, such as highlighting whether statements are from personal experience or professional training. As indicated by both the constructivist perspective and the results of this study, open discussion is

essential throughout the counseling process, as both counselors and clients may change their conceptualization over time as they encounter new experiences and information.

For counselors, insights provided by the current study lend themselves to some significant improvements that can take place in counseling practice as it relates to sexuality counseling, regardless of a counselor's concentration or work setting. First, because sexuality is developmental and multi-dimensional, it is important that counselors recognize the relevance of sexuality in clients' overall wellness and functioning rather than compartmentalizing sexuality as an isolated presenting problem in counseling. Clients may not independently talk about their sexual functioning, so it is important to invite clients that the counseling setting is a safe place to discuss sexuality as a universal human experience rather than in the context of dysfunction. Integration of sexuality from the point of assessment throughout the counseling process will normalize its inclusion in counseling sessions. Second, self-motivation is essential in increasing awareness about sexuality. Self-awareness is highly valued in sexuality counseling, as is self-education beyond the limited professional sexuality training. Seeking information through educational websites and additional training opportunities, such as presentations and workshops, can provide resources both for counselors and clients. In addition to sexual values and beliefs, one area of self-awareness that requires significant reflection for counselors is recognizing the degree of detachment, or "objectivity," in providing sexuality interventions, which may not be entirely feasible. Rather, an alternative response might be to use bracketing to manage subjective responses and construct a

working definition of sexuality that can be applied with clients. Finally, seeking supervision, consultation, and networking as it relates to sexuality before sexuality is presented in the counseling process will better prepare counselors to help clients with issues related to sexuality. Because sexuality is a sensitive area, strong emotions and reactions are common when providing sexuality counseling. Counselors could initiate conversations about their subjective experiences providing sexuality counseling to assist with their own professional development in this area.

The results of this study offer implications for counselor educators as well. For counselors-in-training (CITs), the constructivist nature of the language and meaning attributed to sexuality lends itself to recognizing that CITs enter their graduate programs with varying experiences that influence their definition of sexuality. Because sexuality counseling training is not required, CITs may be largely unaware of their own perceptions related to sexuality until they are confronted with a counseling experience in which sexuality concerns arise. Because there isn't a guarantee that CITs will have an opportunity in practicum or internship courses to address sexuality, it is essential that Counselor Educators create opportunities within the program for CITs to explore and address their perceptions related to sexuality and learn how to provide counseling interventions to address sexuality concerns. In this manner, CITs will be more aware of the constructivist nature of sexuality.

The importance of role modeling and mentoring regarding sexuality training cannot be over-emphasized, as CITs may have only their subjective experiences to rely

upon for information regarding sexuality. Counselor educators assigned to teach courses or topics related to sexuality need to be comfortable with the topic to avoid communicating discomfort and reinforcing avoidance in counselors-in-training. Counselor educators who are uncomfortable with the topic can take appropriate steps to confront their own discomfort and/or refrain from teaching these courses. Ideally, programs would most benefit from hiring faculty who has experience in the area of addressing and/or training about sexuality. Second, counselor education programs may increase exposure to sexuality for counselors-in-training. This objective can be accomplished in one of three ways: increasing the availability of courses in sexuality counseling, increasing training opportunities in other ways, such as workshops and online training series, and integrating sexuality counseling examples across courses, regardless of the concentration area. Third, counselor educators can become more involved in advocacy of more clarity in defining the parameters of sexuality counseling through participating in research and correspondence with organizations that set standards regarding sexuality counseling, such as AASECT. Counselor Educators can become involved in political advocacy to increase awareness of the scope of sexuality counseling, providing education regarding the developmental nature of sexuality, and prevention programs through connecting sexuality to other dimensions of wellness, particularly as it relates to limitations placed upon addressing sexuality in the school setting. Such advocacy is particularly warranted at the state levels due to the variation in laws. Finally,

new training practices and competencies should be considered that are based on a wellness perspective.

Counselor supervisors also benefit from the results of this study. Having graduated from programs that pre-dominantly do not require a sexuality counseling training course, supervisees may experience some of the same struggles addressing sexuality as CITs, including lack of awareness, lack of training in sexuality counseling, and lack of understanding the constructivist nature of sexuality. Because of the limitations in graduate level training, it is essential that supervisors have a heightened awareness of sexuality as an area that needs more emphasis in supervision. Just as clients are reluctant to initiate discussions about sexuality with their counselors, so counselors may be hesitant to initiate conversations with their supervisors about their struggles providing appropriate interventions and managing their own subjective experiences related to sexuality. Supervisors can invite and encourage supervisees to talk about sexuality in the supervision sessions and assess supervisees' knowledge and competency in this area. Furthermore, supervisors can encourage their supervisees to seek out training opportunities, address sexuality with clients, and target their own areas of discomfort to minimize potential negative impact on clients.

Further research is necessary in sexuality counseling. Emphasis on clarifying the realms of sexuality to create a definition that can be utilized in sessions with clients would be beneficial, given the results indicating that counselors are careful not to interject their own definitions into the process. In addition, research regarding

counselors' experience and effectiveness providing sexuality counseling would be beneficial. Examining the difference between counselors with graduate level training preparation and those without would help to highlight the impact of training on counselors. Finally, more research needs to be conducted on positive, normal, and pleasurable aspects of sexuality and sexual functions to provide counselors with a guide to use in counseling that is not based on or influenced by their own values.

Further research that may address some of the limitations in the current study would involve conducting the same study with different concentrations to compare the conceptualization of sexuality and sexuality counseling between school counselors, clinical mental health counselors, and marriage, couples, and family counselors. It would also be beneficial to conduct individual interviews in a traditional manner to increase the depth of information reported. Increasing the diversity among participants and expanding the geographical pool would also enhance the study. Another significant contribution to research would be to conduct a study with school counselors on addressing sexuality due to the legal constraints and lack of licensure requirements used as selection criteria in the current study. Finally, attending a national professional conference and recruiting participants in person may have enhanced participation in the study.

Conclusion

This study investigated counselors' perception of the constructs "sexuality" and "sexuality counseling" from a phenomenological perspective. Results of this study indicated that three themes were important to counselors' perception of these constructs.

The first theme was that sexuality is multi-dimensional. The second theme was that sexuality is developmental. The third theme, sexuality counseling is dialectical, included three sub-themes, wellness/dysfunction, subjectivity/objectivity, and flexibility/structure. The fourth theme, sexuality training in Counseling is insufficient, included two sub-themes, minimal impact of current training and need for further training. Counselors overwhelmingly highlighted the relevance of sexuality regardless of concentration or work setting, negating the position that sexuality counseling is a specialty.

This study highlights the importance of sexuality as a multi-dimensional, developmental experience that warrants greater focus in counselor education and supervision. As counselors are provided with increased training, they could become more effective in addressing sexuality concerns with clients.

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Appendix A

Focus Group Participation Demographical Survey

1. Which race/ethnicity best describes you?

- ☐ American Indian or Alaskan Native
- ☐ Asian / Pacific Islander
- ☐ Black or African American
- ☐ Hispanic American
- ☐ White / Caucasian

Other (please specify)

2. Which category below includes your age?

- ☒ 17 or younger
- ☐ 18-20
- ☐ 21-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60 or older

3. What is your gender?

4. In what state or U.S. territory do you live?

- ☐ Alabama
- ☐ Alaska
- ☐ American Samoa
- ☐ Arizona
- ☐ Arkansas
- ☐ California
- ☐ Colorado
- ☐ Connecticut
- ☐ Delaware
- ☐ District of Columbia (DC)
- ☐ Florida
- ☐ Georgia
- ☐ Guam
- ☐ Hawaii
- ☐ Idaho
- ☐ Illinois
- ☐ Indiana
- ☐ Iowa
- ☐ Kansas
- ☐ Kentucky
- ☐ Louisiana
- ☐ Maine
- ☐ Maryland
- ☐ Massachusetts
- ☐ Michigan
- ☐ Minnesota
- ☐ Mississippi
- ☐ Missouri

- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Northern Marianas Islands
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Virgin Islands
- Washington
- West Virginia
- Wisconsin
- Wyoming

5. Please indicate your graduate degree and concentration area.

- ☐ Masters (i.e. Ed.S., M.S., M.A.)--School Counseling
- ☐ Masters (i.e. Ed.S., M.S., M.A.)--Community/Clinical Mental Health Counseling
- ☐ Masters (i.e. Ed.S., M.S., M.A.)--Marriage, Couples, and Family Counseling
- ☐ Masters (i.e. Ed.S., M.S., M.A.)--Other Concentration
- ☐ Doctorate(i.e. Ph.D.)--Counselor Education and Supervision
- ☐ Doctorate(i.e. Ph.D.)--Other Concentration
- Other (please specify)

6. Are you currently professional licensed in your state (please indicate yes or no and information regarding your licensure)?

7. Are you currently practicing counseling at least part time?

- ☒ Yes
- ☐ No

8. How many years of post-licensure counseling experience do you have?

- ☒ less than 5
- ☐ between 5 and 10
- ☐ between 10 and 15
- ☐ over 15

9. Please describe the setting(s) in which you currently practice counseling.

10. In your clinical experience, with how many clients have you addressed sexuality as a focus of counseling?

- ☒ None
- ☐ One
- ☐ More than One

11. Please indicate your training experience in sexuality.

- ☐ one or more courses in sexuality as requirement of degree program
- ☐ one or more courses in sexuality as an elective of degree program
- ☐ attendance to workshop(s), presentation(s), or similar professional development
- ☐ self-conducted research
- ☐ addressed in supervision
- ☐ no training

12. Please indicate your level of comfort with engaging in discussions on social networking sites (i.e. facebook, myspace, etc.)

- ☒ Not comfortable
- ☒ Fairly comfortable
- ☒ Moderately Comfortable
- ☒ Very Comfortable

13. Would you be willing to participate in a secure, anonymous online discussion group with other counselors about sexuality interventions? (anticipated one time, two hours)

- ☒ Yes
- ☒ No


14. What day/time would be most convenient for you to participate in an online discussion? (EST) Please check as many as apply

- ☐ Saturday
- ☐ 7-9 am
- ☐ 9-11 am

Other (please specify)

15. What interests you about participating in a discussion group about sexuality interventions?

16. Please indicate your contact information if you would like to participate in the study (i.e. email, phone number, etc.). If you would not like to participate, please indicate "not interested."

A rectangular text input field with a thin gray border. On the right side, there is a vertical scroll bar with a small upward-pointing arrow at the top and a downward-pointing arrow at the bottom. The bottom of the field features a horizontal scroll bar with a checkered pattern and a small rightward-pointing arrow on the right side.

Appendix B

Letter of Invitation to Participate in the Study
Study Title: A Constructivist Examination of Counselors' Conceptualization of
"Sexuality": Implications for Counselor Education

Dear Licensed Professional,

My name is Wynn Dupkoski. I am a doctoral candidate in the Counselor Education program at the University of South Carolina. For my dissertation, I am conducting a study on the experiences of counselors providing sexuality interventions with clients. I hope to learn about your experiences in order to benefit our understanding of sexuality counseling. The title of the study is "A Constructivist Examination of Counselors' Conceptualization of 'Sexuality': Implications for Counselor Education"

If you are willing to consider participating in an online focus group to discuss sexuality counseling, please follow the following link to complete a short survey:

<https://www.surveymonkey.com/s/QRZBDZX>

I understand that your time is precious, and I appreciate your willingness to assist me both in completing this very important step in my professional development and in providing the counseling field with useful information regarding what sexuality counseling entails from the practitioner's perspective. Completing this survey will only take about ten minutes, and participating in the discussion group is anticipated to take about two hours in a secure, online chat program. The use of the web to conduct this discussion group is intended to provide greater flexibility and reduce the time and financial constraints of participation. Thank you very much in advance.

With kind regards,

Wynn Dupkoski, M.S., LPC/S, NCC

Cell Phone: 803-210-7422

wndupkoski@gmail.com

Appendix C

Informed Consent for Study Participation University of South Carolina Department of Educational Studies Counselor Education Program Project Description and Participant Consent Form

Title: A Constructivist Examination of Counselors' Conceptualization of "Sexuality": Implications for Counselor Education **Who we are and why this research**

The Principal Investigator, Wynn Dupkoski, M.S., LPC/S, NCC, a doctoral candidate in the Counselor Education Program at the University of South Carolina, is researching the experience of counselors providing sexuality interventions to clients. This research was inspired by the Wynn's counseling work with clients regarding sexuality. It is the intent of the researchers to examine your experience regarding providing sexuality interventions to clients in your area of counseling concentration. Your participation in this research will contribute to a greater understanding of the process of providing sexuality interventions.

Members of the dissertation committee in this research are Donna Gibson, PhD, LPC, Kathy Evans, PhD, and Moody Crews, PhD, also with the Counselor Education Program at the University of South Carolina and Susan Marciano, PhD, LISW-CP, a private practitioner and supervisor.

What does your involvement entail?

Your participation will begin only after you have reviewed the provided information for study participation and successfully logged into the website to create your profile. Prior to logging into the website, you are invited to ask me any additional questions you may have about the research. Your review of the materials and consent to participate will be implied by logging onto the website and creating a profile for yourself. Your participation in this study is voluntary. You may choose to withdraw your participation in this study at any time.

Once you have consented to participate in the study and a time has been scheduled for the focus group to take place, you will be emailed a password to access the 24im website. You will then create a profile that includes as much or as little information about yourself as you wish to share with the group. Wynn will

provide you with an opportunity to discuss any questions that you may have prior to participating in the interview. Your scheduled participation will involve logging onto 24im on the scheduled day and time for approximately two hours. The discussion will be documented in a manner that will not identify you as a study participant. The discussion group content will be copied to a word document stored using a password protected web-based storage program (www.dropbox.com) accessible only to the principal investigator and two additional research assistants. Any information or disclosure that includes identification of yourself will only be known to the principal researcher and will either be removed or concealed in the transcription process to maintain your confidentiality. Following transcription, you will be provided with a copy of the discussion to review for accuracy and/or clarification on your responses.

Risks to you during research

There are no significant risks to participants in this study. Although you may experience some distress regarding the sensitive nature of the topic, it is anticipated that this impact will be no more than would occur in an educational or training environment. In addition, you are welcome to contact the investigator privately at any time. You may opt out of the study at any time or choose to not answer a specific question without negative repercussions. All data will be kept anonymous, and any identifying information will be deleted prior to the researchers analyzing the data.

Will you benefit from your participation?

At the conclusion of the study, you will be provided with a list of resources from which you will be able to select an item to benefit your counseling practice. In addition, it is the hope of the researchers that the data collected from your participation will contribute to counseling literature. It is also the hope that this research will expand our understanding of providing sexuality counseling to clients.

Your participation is voluntary.

Your participation is voluntary. If you choose not to participate, your choice will not lead to any negative consequences. You may choose to withdraw your participation at any time. You may do so by emailing me, Wynn Dupkoski, at wndupkoski@gmail.com and informing me of your decision to no longer participate in the study.

All research remains confidential.

All data materials remain confidential and your name will not be attached to any data. If any identifying information is disclosed during the interview, it will be concealed or deleted prior to analysis. No references will be made which

could link individual participants to the research. All data will be kept in a secure location. All electronic data will be password protected.

CONTACT INFORMATION

The University of South Carolina wants to make sure you are treated in a fair and respectful manner. If you have any questions or concerns about your treatment in this process, please contact the University's Office of Research Compliance at 803.777.7095. Additionally, if you have specific questions about this project, feel free to contact me, Wynn Dupkoski, at 803.210.7422.

Appendix D

Follow up for 24im Site Instructions for Participants

Study Title: A Constructivist Examination of Counselors' Conceptualization of
"Sexuality": Implications for Counselor Education

Hi!

This is a final email to confirm that you should have received an email providing you with the site and log in information for the focus group. You are currently scheduled to participate on ____ at _____. I look forward to a dynamic discussion with yourself and other participants. Please take time at your convenience to practice logging in and creating a profile for yourself. You will note that I have used only your initial(s) to maintain your confidentiality; however, you are welcome to include as much or as little information about yourself when creating your profile. Once you have logged in, your assigned group for the study is labeled _____. Have a wonderful week, and I will "see" you soon!

Wynn